

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16296

CERTIFICATE OF DEATH

16287

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville			c. LENGTH OF STAY IN lb 8 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Knollwood Manor N/Home				d. STREET ADDRESS Box #151 Rt. #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mr. James Albert				4. DATE OF DEATH Month Dec. Day 22 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1882		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 02 Days 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Bricklayer		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (unknown) Portaskiewicz				14. MOTHER'S MAIDEN NAME (unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216/05/6510		17. INFORMANT Steven Albert (Son)		Address Same As # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) Myocardial infarction DUE TO (c) Arteriosclerotic Cardiovascular disease							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 28, 1964 , to Dec 22, 1967 , that (I) (we) last saw the deceased alive on Dec 22, 1967 , and that death occurred at 4:30 PM , from causes and on the date stated above.							
22a. SIGNATURE Ray M. Smith				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec. 23, 1967	
22c. PHYSICIAN'S NAME (Type) Ray M. Smith MD				22d. ADDRESS Hahn Professional Bldg., Severna Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 26, 67		23c. NAME OF CEMETERY OR CREMATORY Our Lady of the Field		23d. LOCATION (City or Town) (County) (State) Millersville, A.A. Md.	
24. FUNERAL DIRECTOR R.P. Ware				25a. REC'D BY REGISTRAR DEC 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
24. ADDRESS Singleton Funeral Home, Glen Burnie, Md.							

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[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are visible.]

16297

CERTIFICATE OF DEATH

16288

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb 30 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 316 - 5th Ave. S/E		d. STREET ADDRESS 316 - 5th Ave/ S/E	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle OSMAN Last ALLEN		4. DATE OF DEATH Month Dec. Day 8 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 May 1900
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Salesman (ret) Park Circle	
11. BIRTHPLACE (County & State, or foreign country) Severn, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry E. Allen		14. MOTHER'S MAIDEN NAME Annie C. Griffith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 217-01-9240	
17. INFORMANT Mrs. Blanche M. Allen- Wife		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO (b) Advanced Atherosclerotic Heart Disease DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-21, 1963 to 12-8, 1967 , that (I) (we) last saw the deceased alive on 12-8, 1967 , and that death occurred at 5:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Wayne B. Tate		22b. DATE SIGNED 12/9/67	
22c. PHYSICIAN'S NAME (Type) Wayne B. Tate		22d. ADDRESS Central Ave. Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/11/67	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.	23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.
24. FUNERAL DIRECTOR Singleton Funeral Home/Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE DEC 11 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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CERTIFICATE OF DEATH

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16298

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Rt-5, Box-181			
3. NAME OF DECEASED (Type or print) First Homer Middle ANDERSON Last				4. DATE OF DEATH Month December Day 20 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 25, 1886	
9. AGE (In years last birthday) yrs. 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (County & State, or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Anderson				14. MOTHER'S MAIDEN NAME Sally (Campbell) Anderson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Eugene Anderson Annapolis Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Gen Delirium + Sincerely DUE TO (b) Gen Cert. & Fr. Left Hip. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State)	
21. I certify that (I) (he) attended the deceased from 1967 , 19 Dec. 20 , 19 67 , that (I) (he) saw the deceased alive on Dec. 20 , 19 67 , and that death occurred at 4:20 AM M, from causes and on the date stated above.							
22a. SIGNATURE Robert R. Hahn				22b. DATE SIGNED 12-20-67		22c. PHYSICIAN'S NAME (Type) Robert R. HAHN	
22d. ADDRESS P.O. Box 73 Severna Park							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 22, 1967		23c. NAME OF CEMETERY OR CREMATORY Old Hillman Cem		23d. LOCATION (City or Town) (County) (State) Candor Del	
24. FUNERAL DIRECTOR J. Harvey Williams Federalburg				25a. REC'D BY REGISTRAR DEC 27 1967		25b. REGISTRAR'S SIGNATURE James J. [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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The first of the year was a very cold one, and the
 weather was very disagreeable. The wind was
 very strong, and the rain was very heavy.
 The snow was very deep, and the ice was very
 thick. The water was very cold, and the
 ground was very hard. The trees were very
 bare, and the leaves were very dry. The
 grass was very dry, and the corn was very
 hard. The wheat was very hard, and the
 barley was very hard. The oats were very
 hard, and the rye was very hard. The
 clover was very hard, and the alfalfa was
 very hard. The hay was very hard, and the
 straw was very hard. The wood was very
 hard, and the bark was very hard. The
 leaves were very dry, and the twigs were
 very hard. The branches were very hard, and
 the trunk was very hard. The roots were
 very hard, and the soil was very hard. The
 ground was very hard, and the water was
 very cold. The air was very cold, and the
 sun was very weak. The moon was very
 bright, and the stars were very bright. The
 clouds were very dark, and the sky was
 very dark. The night was very dark, and
 the day was very dark. The weather was
 very bad, and the people were very sad.

The second of the year was a very warm one, and
 the weather was very pleasant. The wind was
 very light, and the rain was very light. The
 snow was very light, and the ice was very
 light. The water was very warm, and the
 ground was very soft. The trees were very
 green, and the leaves were very green. The
 grass was very green, and the corn was very
 green. The wheat was very green, and the
 barley was very green. The oats were very
 green, and the rye was very green. The
 clover was very green, and the alfalfa was
 very green. The hay was very green, and the
 straw was very green. The wood was very
 green, and the bark was very green. The
 leaves were very green, and the twigs were
 very green. The branches were very green, and
 the trunk was very green. The roots were
 very green, and the soil was very green. The
 ground was very green, and the water was
 very warm. The air was very warm, and the
 sun was very strong. The moon was very
 bright, and the stars were very bright. The
 clouds were very light, and the sky was
 very light. The night was very light, and
 the day was very light. The weather was
 very good, and the people were very happy.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 4-64

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16299									
16290									
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A.A.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Friendship</i>			c. LENGTH OF STAY IN 1b <i>30 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Friendship</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>—</i>					d. STREET ADDRESS <i>Route #1</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Bess</i> Middle <i>Armiger</i> Last <i>Armiger</i>					4. DATE OF DEATH Month <i>December</i> Day <i>2</i> Year <i>1967</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 2, 1889</i>		9. AGE (In years last birthday) <i>78</i> yrs.	IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i>	IF UNDER 24 HRS. Hours <i>—</i> Min. <i>—</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Ohio</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John McFarland</i>					14. MOTHER'S MAIDEN NAME <i>Alice J. Goodrich</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>216-12-4872B</i>		17. INFORMANT <i>Mrs. Alice Greenwell, Bristol, Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of pancreas</i> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i>									INTERVAL BETWEEN ONSET AND DEATH <i>one year</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Aug. 1, 1967</i> to <i>Dec 2, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec. 1, 1967</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>Willard F. Smith</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12/2/67</i>		
22c. PHYSICIAN'S NAME (Type) <i>Willard F. Smith, MD</i>					22d. ADDRESS <i>Shady Side, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 4, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Friendship Chr. Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Friendship A. A. Co. Md.</i>		
24. FUNERAL DIRECTOR <i>Hutchins Funeral Home</i>					ADDRESS <i>Owings, Maryland</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 5 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
16300					CERTIFICATE OF DEATH					16291				
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis					c. LENGTH OF STAY IN TB					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital					d. STREET ADDRESS 132 Archwood Avenue					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Walter Herman ASCHE					4. DATE OF DEATH Month December Day 17 Year 19 67									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1899		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) METALURGIST					10b. KIND OF BUSINESS OR INDUSTRY ENGINEER					11. BIRTHPLACE (County & State, or foreign country) Germany				
13. FATHER'S NAME UNKN.					14. MOTHER'S MAIDEN NAME UNKN.					12. CITIZEN OF WHAT COUNTRY?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address ELIZABETH M. ASCHE #2				
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstructive jaundice DUE TO (b) Metastatic DUE TO (c) Gastric Adenocarcinoma										INTERVAL BETWEEN ONSET AND DEATH 1 month 3 mos 15 mos				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour p.m. 19 67					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from July , 19 66 , to Dec. , 19 67 , that (I) was saw the deceased alive on Dec. 16 , 19 67 , and that death occurred at 11:45 A.M. , from causes and on the date stated above.														
22a. SIGNATURE Peter F. Verkow					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED 12-18-67				
22c. PHYSICIAN'S NAME (Type) PETER F. VERKOW M.D.					22d. ADDRESS 1407 Forest Drive, Annapolis, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF 12/19/1967		23c. NAME OF CEMETERY OR CREMATORY HILLCREST CEM.			23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD				
24. FUNERAL DIRECTOR JOHN M. TAYLOR, SON					ADDRESS ANNAPOLIS MD.					25a. REC'D BY REGISTRAR DATE DEC 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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VR A15 (4)
20 M 1/66

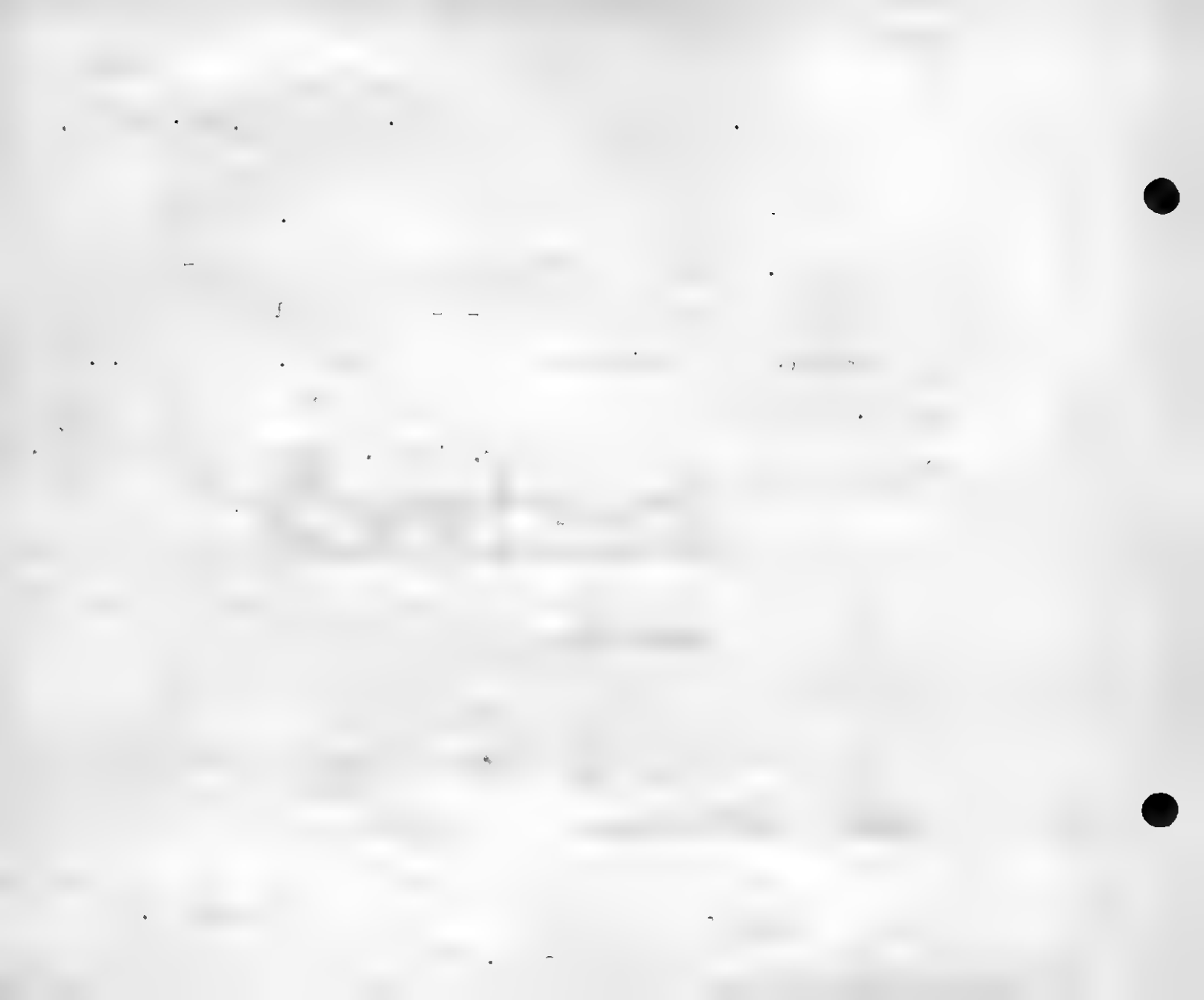
16301

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16293

1. PLACE OF DEATH a. COUNTY Anne Arundel Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. Anne Arundel Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 400 Cresswell Ave. 21225	
3. NAME OF DECEASED (Type or print) Arthur E. Atkinson (ARTHUR EUGENE)		4. DATE OF DEATH 12-12-67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-06
9. AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR: Months 12 Days 12 Hours 67 Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cost Acct		10b. KIND OF BUSINESS OR INDUSTRY Westinghouse	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur E. Atkinson		14. MOTHER'S MAIDEN NAME Mary Van Sant	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Viola P. Atkinson		Address 400 Cresswell Ave. 21225	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Myocardial Infarction DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cholesterol (c) High Blood Pressure			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) High Blood Pressure			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-6- , 19 67 to 12-12 , 19 67 , that (I) (we) last saw the deceased alive on 12-11 , 19 67 , and that death occurred at 4:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE Dr. [Signature]		22b. DATE SIGNED 12-12-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/14/67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Anne Arundel Co.	
24. FUNERAL DIRECTOR McCauley Funeral Home		25a. REC'D BY REGISTRAR DEC 18 1967	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. ADDRESS 237 Patapsco Ave. 21225	



16302

CERTIFICATE OF DEATH

16294

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>2 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Box-36</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>AYERS</u>		4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-10-40</u>
9. AGE (In years last birthday) <u>27</u> yrs		10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FINANCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LOAN CO.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>H. W. AYERS</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Thornton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>KOREA</u>		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>GERHOLDINE AYERS #2</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lobar Pneumonia - left</u> 420x DUE TO <u>Due to influenza</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ADRENAL CORTICAL ATROPHY</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>on Dec 29, 1967</u> to <u> </u> that (I) (we) last saw the deceased alive on <u>Dec 29 1967</u> , and that death occurred at <u>12th PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Willard F. Smith</u>		22b. DATE SIGNED <u>12/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith, M.D.</u>		22d. ADDRESS <u>Shady Side, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-2-1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ROSEDALE MEM. PARK</u>	23d. LOCATION (City or Town) (County) (State) <u>Bucks Pa.</u>
24. FUNERAL DIRECTOR <u>John M. Taylor Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 3 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

16295

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>214 Ditty Court</u>		d. STREET ADDRESS <u>214 Ditty Court</u>	
3. NAME OF DECEASED (Type or print) <u>Annette M. Barnwell</u>		4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1911</u>
9. AGE (In years last birthday) <u>56</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Luther Rohrbaugh</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO <u>213-20-7196</u>		17. INFORMANT <u>Mr. Henry J. Barnwell (husband)</u> # <u>2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>ASHD</u> (b) <u> </u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		19. INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT, NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HCD</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>7/15</u> , 19 <u>57</u> , to <u>12/29</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>12/23</u> , 19 <u>66</u> , and that death occurred at <u>4A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph Taler</u>	22b. DATE SIGNED <u>12/29/67</u>	22c. PHYSICIAN'S NAME (Type) <u>JOSEPH TALER</u>	
22d. ADDRESS <u>85 Ashcroft Rd. Glen Burnie, Md.</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 2 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk.</u>	23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Maryland</u>
24. FUNERAL DIRECTOR <u>E.B. Fleming</u> <u>Singleton Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 2 1968</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. REGISTRAR'S NAME <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/60



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16304

CERTIFICATE OF DEATH

16296

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY in lb 0.0.A	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel			d. STREET ADDRESS 1303 Heathwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FRANCIS Middle L. Last BELL			4. DATE OF DEATH Month Dec. Day 10 Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 May 1927		9. AGE (In years last birthday) yrs 46
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisher Body		10b. KIND OF BUSINESS OR INDUSTRY Fisher Body		11. BIRTHPLACE (County & State, or foreign country) Newburg, West Va.	
13. FATHER'S NAME Carl Bell			14. MOTHER'S MAIDEN NAME Iva Knott		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 232426021		17. INFORMANT Mary Ann Bell (wife) Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____					INTERVAL BETWEEN ONSET AND DEATH 2 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Dec 10 , 19 67 , to Dec 10 , 19 67 , that (I) (we) last saw the deceased alive on Dec 10 19 67 , and that death occurred at 1:00 P.M. from causes and on the date stated above.					
22a. SIGNATURE Robert Dabolins			22b. DATE SIGNED 12-11-67		
22c. PHYSICIAN'S NAME (Type) Robert Dabolins, M.D.			22d. ADDRESS 400 Crain Hwy. N.W. Glen Burnie, Md.		
23a. BURIAL, CREMAT., OR REMOVAL (Specify) Burial	23b. DATE THEREOF 12/13/67	23c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l. Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Singleton Funeral Home/ Glen Burnie, Md.			25a. REC'D BY REGISTRAR DATE DEC 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



16305

CERTIFICATE OF DEATH

16297

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-GLEN BURNIE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-GLEN BURNIE	
c. LENGTH OF STAY IN 1b 1 DAY		d. STREET ADDRESS 202 WICKLOW AVE FERNDALE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BURTON H. BERRY		4. DATE OF DEATH Month Day Year DECEMBER 18 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1892
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James E. Berry, Sr.		14. MOTHER'S MAIDEN NAME Evelyn W. Williamson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 243-20-0738	
17. INFORMANT Mrs. Alma Berry, same as 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4. DUE TO Cerebro-vascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic heart disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 17 , 19 67 , to Dec 18 , 19 67 , that (I) (we) last saw the deceased alive on Dec 18 , 19 67 , and that death occurred at 10:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE Joseph A. Talor, M.D.		22b. DATE SIGNED 12/18/67	
22c. PHYSICIAN'S NAME (Type) JOSEPH A. TALOR, M.D.		22d. ADDRESS 9514 BURKHART Rd. Glen Burnie	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 20 Dec. 1967	23c. NAME OF CEMETERY OR CREMATORY Soule Cemetery	23d. LOCATION (City or Town) (County) (State) Evans Quarter, N. C. Md.
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE DEC 20 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16306

CERTIFICATE OF DEATH

16298

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. 2 Paradise Beach</u>		d. STREET ADDRESS <u>Rt. 2 Paradise Beach</u>	
3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>K.</u> Last <u>BIENER</u>		4. DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7 May 1901</u>
9. AGE (In years lost b rthday) <u>66</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret. red) <u>(ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bieners Bakery</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frederick K. Biener</u>		14. MOTHER'S MAIDEN NAME <u>(unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-34-3146</u>	
17. INFORMANT <u>Mrs. Barbara Biener</u>		Address <u>Same as # 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular disease</u> DUE TO (b) <u>Myocardial infarction</u> DUE TO (c) <u>Old age</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 26, 1967</u> to <u>July 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 26, 1967</u> , and that death occurred at <u>10 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>William G. Geyer</u>		22b. DATE SIGNED <u>Dec-5-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William G. Geyer</u>		22d. ADDRESS <u>156 Milton Ave. - Baltimore, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk.</u>	23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Maryland</u>
24. FUNERAL DIRECTOR <u>Singleton Funeral Home/Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John A. Judge</u>			


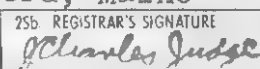
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

16307

CERTIFICATE OF DEATH

16299

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, f institution Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5 mos		c. LENGTH OF STAY IN lb Bowie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital, Annapolis, Md.		d. STREET ADDRESS 12400 Melody Turn, Bowie, Md.	
3 NAME OF DECEASED (Type or print) Cecile Ann Marie Boissonneault		4 DATE OF DEATH Month December Day 12 Year 67	
5 SEX Female	6 COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Sept. 1925
9 AGE (In years last birthday) 42 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Bedford, Maine		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Edgar E. Martel		14 MOTHER'S MAIDEN NAME Amanda Tanguay	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 005 22 1877	
17 INFORMANT Husband		Address Raymond Boissonneault	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PENDING</u> Undetermined 7955 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Deceased was on Dilantin Therapy. It is possible death was due to a seizure & resulting cardiac arrhythmia.			19 WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from DOA 12-12, 1967, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 1955 M, from causes and on the date stated above.			
22a SIGNATURE  A. C. J. BRICKEL, LT MC USNR		22b DATE SIGNED M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c PHYSICIAN'S NAME (Type) A. C. J. BRICKEL, LT MC USNR		22d ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 12-18-1967	23c NAME OF CEMETERY OR CREMATORY St Joseph Church Cem.	23d LOCATION (City or Town) (County) (State) Biddeford, Maine
24 FUNERAL DIRECTOR NALLEY'S FUNERAL HOME, 3200 Rhode Island Ave. N.E., WASHINGTON, D.C.		25a REC'D BY REGISTRAR DEC 18 1967	25b REGISTRAR'S SIGNATURE 

16303

CERTIFICATE OF DEATH

16300

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel County</i> <i>Cramsville State Hospital</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cramsville</i>		c. LENGTH OF STAY IN TB <i>June Jan 29/67</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Cramsville State Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Barbara ELsie</i> First Middle Last <i>Bowen</i>		4. DATE OF DEATH Month <i>12</i> Day <i>29</i> Year <i>1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/26/86</i>
9. AGE (In years last birthday) <i>81</i> yrs		10. IF UNDER 1 YEAR Months <i>2</i> Days <i>3</i> Hours <i>4</i> Min <i>4</i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
13. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		14. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. FATHER'S NAME <i>Silas W Bowen</i>		16. MOTHER'S MAIDEN NAME <i>Fanny Marriott</i>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		18. SOCIAL SECURITY NO <i>218-54-7960</i>	
19. INFORMANT <i>Chert</i>		Address	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Leukemia</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2-3 yrs</i> <i>Several days</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Anemia, Malnutrition, Chronic Brain Syndrome</i>		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>11/29</i> , 19 <i>67</i> , to <i>12/29</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>12/29/67</i> , 19 <i>67</i> , and that death occurred at <i>9P</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Michael J. L. Benedict M.D.</i>		22b. DATE SIGNED <i>12/30/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>L. BENEDICT M.D.</i>		22d. ADDRESS <i>Cramsville State Hospital</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE THEREOF <i>January 4, 1968</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Central Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Barnstow Calvert Md.</i>	
24. FUNERAL DIRECTOR <i>A.A. Harbess - Son, Port Republic, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 3 1968</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

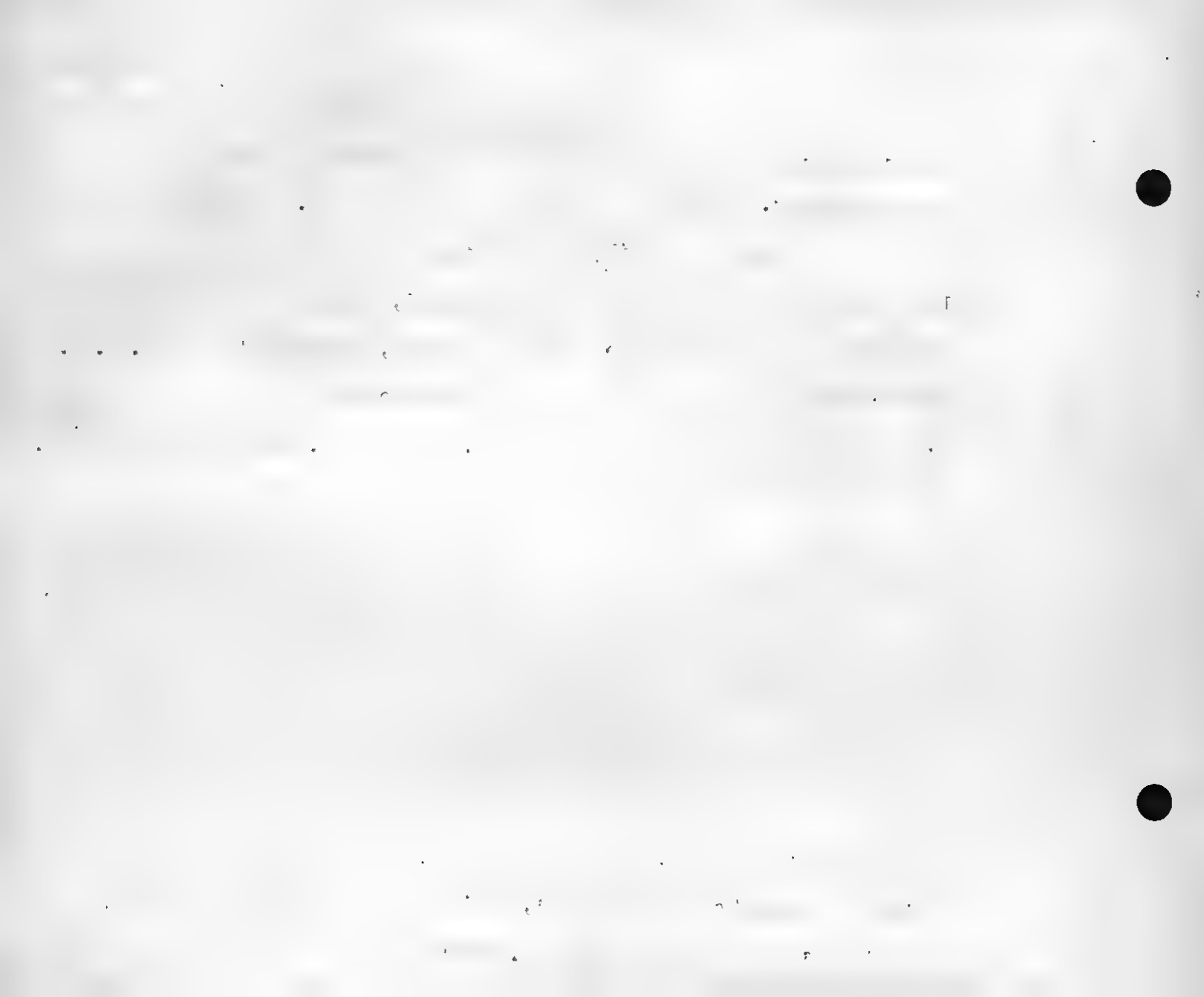
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16301
16301
16301

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brooklyn Park				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brooklyn Park			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 120 Audrey Ave. 21225				d. STREET ADDRESS 120 Audrey Ave. 21225			
3. NAME OF DECEASED (Type or print) First Ray Middle Miller Last Bowers				4. DATE OF DEATH Month Dec. Day 19 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 18, 1900	
9. AGE (In years last birthday) 67 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman		10b. KIND OF BUSINESS OR INDUSTRY Nazarene Church		11. BIRTHPLACE (County & State, or foreign country) Ambler, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Harry Bowers			
14. MOTHER'S MAIDEN NAME Mary Hoffman				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War 1			
16. SOCIAL SECURITY NO. 21225				17. INFORMANT Mrs. Christine W. Bowers 120 Audrey Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Dis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 23 March, 1967 to 19 DEC, 1967 , that (I) (we) last saw the deceased alive on 15 Dec 1967 , and that death occurred at 5:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Benjamin Berdamm				22b. DATE SIGNED 12-21-67		22c. PHYSICIAN'S NAME (Type) Benjamin Berdamm, M.D.	
22d. ADDRESS 615 Harmon Lane				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 12/22/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore, National		23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR McCully Funeral Home				25a. REC'D BY REGISTRAR DEC 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
16310											
16302											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mayo</u>						c. LENGTH OF STAY IN 1b <u>19 Months</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mayo</u>					
3. NAME OF DECEASED (Type or print) <u>Elta Armeda Bowman</u>						4. DATE OF DEATH <u>Dec. 9 1967</u>					
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 8, 1885</u>		9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Kirby, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES LOY</u>						14. MOTHER'S MAIDEN NAME <u>RACHAEL PETERS</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>212-243948</u>					
17. INFORMANT <u>Mrs. Mildred Rickman</u>						Address <u>Mayo, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis and Cardiac failure</u>											
DUE TO (b) <u>Arteriosclerotic Cardiovascular disease</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 30, 1967</u> to <u>Dec. 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec. 9, 1967</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Sylvia M. Linn</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Dec. 9, '67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Sylvia M. Linn</u>						22d. ADDRESS <u>Rt 1 Box 244 Edgewater, Md. 21037</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>12/12/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOTTS CHAPEL</u>		23d. LOCATION (City, town or county) (State) <u>KIRBY W. VA</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Bruce & Hartzler Woodclaw Md</u>						ADDRESS		25a. REC'D BY REGISTRAR <u>DEC 12 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1-67)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16341

16303

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY A.A. Co	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Freetown		c. LENGTH OF STAY IN 1b 18 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box 325 Glen Burnie P.O. Md		e. STREET ADDRESS Box 325 Glen Burnie P.O.	
3. NAME OF DECEASED (Type or print) Lenora NMN Brown		4. DATE OF DEATH Month 12 Day 24 Year 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-9-1889
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 12 Days 24 Hours 19 Mins. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (County & State or foreign country) Anne Arundel Co		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Jerome Manns		14. MOTHER'S MAIDEN NAME Emma Curry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No *****		16. SOCIAL SECURITY NO. 217-07-0001	
17. INFORMANT Evelyn Glenn		Address Glen Burnie P.O. Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H.C.V.D. & Uremia DUE TO Cerebral Swelling (b) Sen Art DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1960 , 19 to 1967 , 19, that (I) (we) last saw the deceased alive on 12-15-67 19, and that death occurred at 7:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Robert R. Hahn		22b. DATE SIGNED 12-25-67	
22c. PHYSICIAN'S NAME (Type) Robert R. HAHN		22d. ADDRESS P.O. Box 73 Severna Park, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-27-67	23c. NAME OF CEMETERY OR CREMATORY Town Neck	23d. LOCATION (City or Town) (County) (State) Anne Arundel Md
24. FUNERAL DIRECTOR C.E. Hicks, 111		ADDRESS Annapolis, Md	
25a. REC'D BY REGISTRAR DATE JAN 2 1968		25b. REGISTRAR'S SIGNATURE W. Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

16312

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16304

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Convul. Center</u>				d. STREET ADDRESS <u>Box #36</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rosemary Buckingham</u>				4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1967</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/25/39</u>		9. AGE (In years lost birthday) <u>28</u> yrs	IF UNDER 1 YEAR Months <u>2</u> Days <u>28</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Lady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter L. Boushell</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Mavisette</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Mrs Mildred Law (Mother)</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Generalized melanomatosis</u> DUE TO (c) <u>Heart failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 29, 1963</u> , to <u>Dec 23, 1967</u> , that (I) (we) lost saw the deceased alive on <u>Dec 23, 1967</u> , and that death occurred at <u>4:20 AM</u> , from causes on and on the date stated above							
22a. SIGNATURE <u>Robert Dabolas</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>12/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert Dabolas, M.D.</u>				22d. ADDRESS <u>406 L'Anson Hwy. 7th.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 26, 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore md.</u>	
24. FUNERAL DIRECTOR <u>R.V. Singleton</u>				ADDRESS <u>Glen Burnie, md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 27 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>James Jones</u>			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16313

CERTIFICATE OF DEATH

16305

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hollywood Manor Nursing Home</u>				d. STREET ADDRESS <u>415 Sylvview Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Henry</u> Last <u>Dudaj</u>				4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 March 1904</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>73</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rigger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>MD 1</u>		17. INFORMANT <u>Mrs. Florence Hajerowicz, same as 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 481X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Viral respiratory infection (Influenza?)</u> DUE TO (c) <u>-----</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Urinary tract infection, Arteriosclerosis, Chronic organic brain syndrome</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , <u>1965</u> , to <u>25 Dec</u> , <u>1967</u> , that (I) (we) last saw the deceased alive on <u>26 Nov</u> , <u>1967</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles W. Kinzer</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>27 Dec 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles W. Kinzer, M. D.</u>				22d. ADDRESS <u>16 Murray Ave., Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>28 Dec. 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Griley Funeral Home, Glen Burnie, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Michaela Judge</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

16314

16306

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 18 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS 119 Clay Street	
3. NAME OF DECEASED (Type or print) Sophie First Brown Last or- Sophia -Elizabeth- or BUNCH		4. DATE OF DEATH Month December Day 24 Year 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 11, 1906
9. AGE (in years) 61		10. IF UNDER 1 YEAR Months 12 Days 14 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chamber maid		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary Gross	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 220-03-5399	
17. INFORMANT Helen Dancey		Address 119 Clay St Annapolis Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Pulmonary Embolus DUE TO (b) Arteriosclerotic Heart DUE TO (c) Probable Carcinoma of the		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 8 months ago		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 11, 19 67 to Dec 24, 19 67 that (I) (we) last saw the deceased alive on December 24 19 67 , and that death occurred at 11:12 p.m. M, from causes and on the date stated above.			
22a. SIGNATURE R. L. Richardson		22b. DATES SIGNED 12/27/67	
22c. PHYSICIAN'S NAME (Type) R. L. Richardson, M.D.		22d. ADDRESS 110-Clay St Annapolis Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-28-67	23c. NAME OF CEMETERY OR CREMATORY Brewer Hill	23d. LOCATION (City or town) (County) (State) Annapolis A.A. Md
24. FUNERAL DIRECTOR C.E. Hicks, 111		25a. REC'D BY REGISTRAR 2 1968	
ADDRESS Annapolis, Md		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

16315

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16307

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY F.F.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS Rt 1 Box 5 Crownsville	
3 NAME OF DECEASED (Type or print) PEARL ANN CARICO		4 DATE OF DEATH December 26, 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH FEB-2-1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) 56 yrs
11 BIRTHPLACE (State or foreign country) Pound-Va		12 CITIZEN OF WHAT COUNTRY USA	
13 FATHER'S NAME LARSEN		14 MOTHER'S MAIDEN NAME ADA MEADE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT ORLENA E. CARLO		Address 3038-E. N. H. H.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE OF DEATH 1/2/68	
23c. NAME OF CEMETERY OR CREMATORY St. Carmel Cem.		23d. LOCATION (City or town) (County) (State) 5712 O'Donnell St (Hd)	
24. FUNERAL DIRECTOR T. Fisher (1920 Eastern Ave)		25a. REC'D BY REG STR JAN 2 1968	
		25b. REGISTRAR'S SIGNATURE Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16316

16308

1 PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>1 Day</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md</u>		d. STREET ADDRESS <u>RIGGS AVE. (208)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. Gen Hosp</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Elith Skipewith Carr</u>		4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-19-97</u>
9. AGE (in years last birthday) <u>70</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Newton H Skipewith</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Powell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>21470334</u>	
17. INFORMANT <u>H.S. Carr</u>		Address <u>Severna Park, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO <u>Aspiration of Vomitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Severe Emphysema - Gastritis</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> , 19 <u>60</u> , to <u>1967</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-9-67</u> , 19 <u>67</u> , and that death occurred at <u>8 AM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Hahn</u> M.D.		22b. DATE SIGNED <u>12-9-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		22d. ADDRESS <u>P.O. Box 73 Severna Park</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/12/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St James Ch. Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Lathin AA Md</u>	
24. FUNERAL DIRECTOR <u>Robert L. Binnanco</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Severna Park, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>DEC 13 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1631

16309

1 PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>2.5</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS (Eastport)</u>		d. STREET ADDRESS <u>39 Dean St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SAMUEL</u> First Middle Last		4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-16</u>
9. AGE (In years lost birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>ANNE ARUNDEL, MD</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>William Carr</u>		14 MOTHER'S MAIDEN NAME <u>Alice</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>UNKNOWN</u>	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))			
PART I DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a)		<u>Respiratory failure</u>	
DUE TO		<u>Cardiac Decompensation</u>	
(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last)		DUE TO	
		<u>Bilateral Pneumonitis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>44</u> (this hospital) attended the deceased from <u>12-17</u> , 19 <u>67</u> , to <u>12-10</u> , 19 <u>67</u> , that (1) <u>we</u> last saw the deceased alive on <u>12-10</u> , 19 <u>67</u> , and that death occurred at <u>4A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Charles A. Greene</u>		22b. DATE SIGNED <u>12/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles A. Greene, M.D.</u>		22d. ADDRESS <u>Johns Hopkins Hospital-Baltimore</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/14/67</u>		23b. DATE THEREOF <u>Broadneck Cemetery Broadneck A.A. Md.</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATED ON (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>J.B. Johnson</u>		25a. REC'D BY REGISTRAR <u>DEC 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

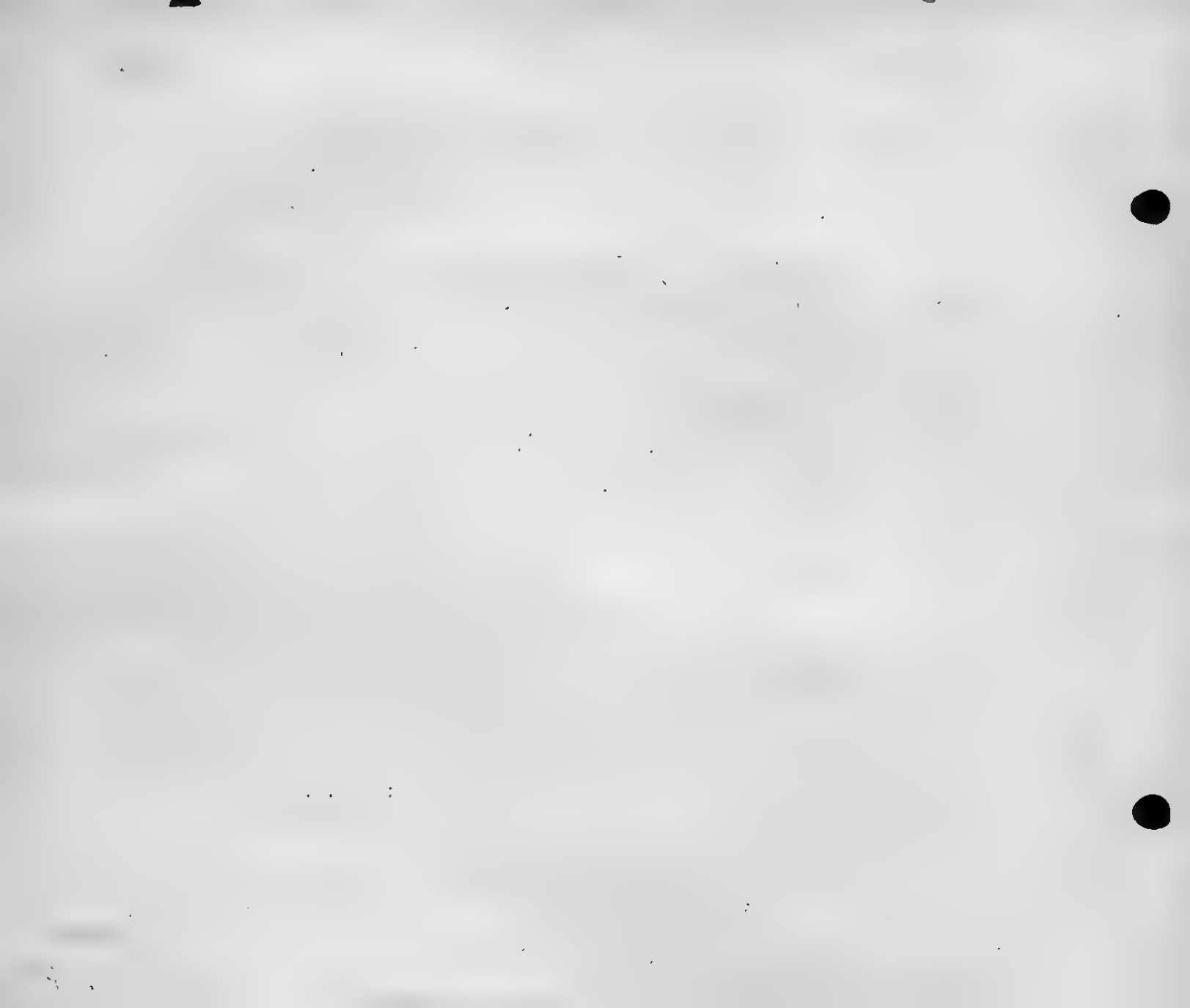
VR A15 14
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16318									
CERTIFICATE OF DEATH									
16310									
1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital					e STREET ADDRESS 27 Murray Avenue			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last James Preston CHANCE					4 DATE OF DEATH Month Day Year December 8 19 67				
5. SEX Male		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH September 6, 1904		9 AGE (In years last birthday) yrs 63	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B & O R.R. CO.		10b KIND OF BUSINESS OR INDUSTRY RAILROAD		11 BIRTHPLACE (County & State, or foreign country) Annapolis, Maryland			12 CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME BENJAMIN F. CHANCE					14. MOTHER'S MAIDEN NAME KATHERINE M. NEMAR				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO ---		17. INFORMANT Mrs. JOHN GREER #2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C. Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Arteriosclerotic Cerebral vascular disease DUE TO (c) Ischemic									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchopneumonia									19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 4/67 , 19 to 12/8 , 19 67 , that (I) (was) last saw the deceased alive on 12/7 , 19 67 , and that death occurred at 12:55 A.M. , from causes on and on the date stated above.									
22a. SIGNATURE R. Biern					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12/8/67		
22c. PHYSICIAN'S NAME (Type) Robert Biern, M. D.					22d. ADDRESS 121 Cathedral St., Annapolis, Maryland.				
23a. BURIAL, CREMATION, REMOVAL (Type)		23b. DATE THEREOF 12-10-67		23c. NAME OF CEMETERY OR CREMATORY ST. ANNES		23d. LOCATION (City or Town) (County) (State) Annapolis A.H. M.D.			
24. FUNERAL DIRECTOR John M. G. L. & Sons, Annapolis, Md.					25a. REC'D BY REGISTRAR DATE DEC 12 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
20M 568

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
16311																			
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>1109 Eastport Terrace</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>Earl Fred CHANEY Sr.</u> First Middle Last						4. DATE OF DEATH <u>December 31 1967</u> Month Day Year													
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 23, 1910</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. AGE (in years last birthday) <u>57</u> yrs. 10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> 11. IF UNDER 24 HRS. <u>Hours</u> <u>Min.</u>													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>YACHT YARD</u>						11. BIRTHPLACE (County & State, or foreign country) <u>Annapolis Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>					
13. FATHER'S NAME <u>THOMAS CHANEY</u>						14. MOTHER'S MAIDEN NAME <u>EMMA BROWN</u>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>YES WWII</u>						16. SOCIAL SECURITY NO. <u>220 05 1471</u>						17. INFORMANT <u>MADELEINE E. CHANEY #2</u> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) <u>Cancer of stomach</u> <u>Cardiac arrest</u> <u>Interval between onset and death</u> <u>unknown</u>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>November, 1967</u> to <u>12/31, 1967</u> , that (I) (we) last saw the deceased alive on <u>12/31, 1967</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above.												22a. SIGNATURE <u>Richard I. Hachman</u> M.D.		22b. DATE SIGNED <u>1/2/68</u>					
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hachman, M.D.</u>						22d. ADDRESS <u>16 Murray Ave. Annapolis Md</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>						23b. DATE THEREOF <u>1-4-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. ANNE'S</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis A.A. MD.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>						25a. REC'D BY REGISTRAR <u>JAK</u> DATE <u>1 1968</u>						25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>							



FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16320

16312

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ch. C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN lb <u>Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>196 Clay Street</u>				d. STREET ADDRESS <u>196 Clay Street</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>DOROTHY Blackstone COATES</u>				4 DATE OF DEATH Month Day Year <u>December 2 19 67</u>			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>Negro</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> D VORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>12-24-1936</u>	
9 AGE (In years last birthday) y/s <u>30</u>		10 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11 BIRTHPLACE (State or foreign country) <u>IND.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Herbert Blackstone</u>				14 MOTHER'S MAIDEN NAME <u>Waisey Kross</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO.		17 INFORMANT <u>Waisey Moulden</u> Address <u>196 Clay St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>+90X</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Edward F. Wilson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Edward F. Wilson, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county) <u>December 2, 1967</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>12-6-1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		23d LOCATION (City or town) (County) (State) <u>Annapolis, Md.</u>	
24 FUNERAL DIRECTOR <u>William Reese</u>				25a REC'D BY REG. STR. 1967 <u>Anna M.C.</u>		25b REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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6 6

16321

CERTIFICATE OF DEATH

16313

1. PLACE OF DEATH a. COUNTY AnneArundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY AnneArundel	
b. CITY OR TOWN (If outside corporate limits, write city or town) Glen Burnie		c. LENGTH OF STAY IN 16 Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 1210 Broadview Blvd.	
3. NAME OF DECEASED (Type or print) Edgar P. Cockerill		4. DATE OF DEATH Month 12 Day 19 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-03
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 4 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during past year, or state if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Cockerill		14. MOTHER'S MAIDEN NAME Alice Fritchard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 615-05-4967	
17. INFORMANT Patients Chart.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1530 IMMEDIATE CAUSE (a) Massive pulmonary embolism DUE TO (b) Cancer of ascending colon DUE TO (c) Anticoagulation - general		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anticoagulation - general		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 8, 1967 , to Dec. 19, 1967 that (I) (we) last saw the deceased alive on Dec. 19, 1967 , and that death occurred 6:20am , from causes and on the date stated above.			
22a. SIGNATURE E. Roderick Shipley		22b. DATE SIGNED Dec. 21, 1967	
22c. PHYSICIAN'S NAME (Type) E. Roderick Shipley, M.D.		22d. ADDRESS Camp Meade Rd., Linthicum, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 22 Dec. 67	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial		23d. LOCATION (City or Town) (County) (State) Ellridge, Maryland	
24. FUNERAL DIRECTOR Kirkley's Funeral Home, Glen Burnie, Md.		25a. REC'D BY REGISTRAR DEC 22 1967	
25b. REGISTRAR'S SIGNATURE Johnas Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

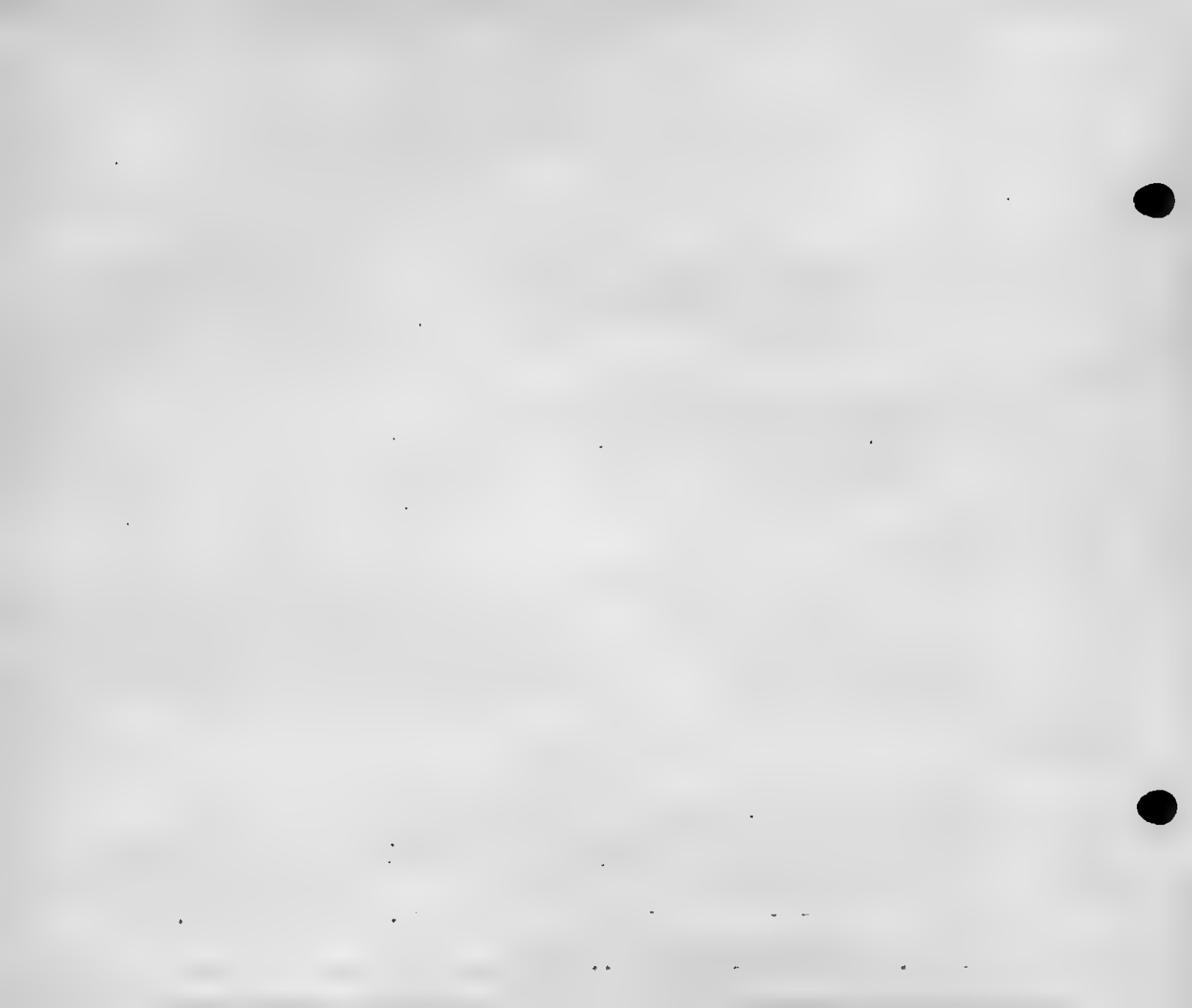


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16322						16314					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <i>Anne Arundel Co.</i> MARYLAND						a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stonington Md.</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore, Maryland</i>					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS <i>1014 W. Guilford Street</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Stonington Nursing Home</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <i>JOHN J Coleman</i>						4. DATE OF DEATH Month Day Year <i>12/22/1967</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2/28/96</i>		9. AGE (In years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Street Cleaner</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		IF UNDER 24 HRS. Hours Min.			
13. FATHER'S NAME <i>JOHN G Coleman</i>						14. MOTHER'S MAIDEN NAME <i>Kate Lailey</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>Yes 512036P 418 218-0200-A Mks/Bright-Hoff-Trend (deceased)</i>						16. SOCIAL SECURITY NO. 17. INFORMANT Address <i>Mrs. Bright-Hoff-Trend (deceased)</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiomyopathy Congestive</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Arteriosclerotic Cardiovascular Disease</i>											
(c) <i>Senility</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>12-1-1964</i> to <i>12-22-1967</i> , that (I) (we) last saw the deceased alive on <i>12-22-1967</i> , and that death occurred at <i>2</i> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Richard H. Hunt</i>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <i>Richard H. Hunt</i>						22d. ADDRESS <i>100 Cherry Lane, Glen Burnie, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>10-26-1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cem.</i>				23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>George J. Gence</i>						25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE <i>DEC 28 1967</i>					



16323

CERTIFICATE OF DEATH

16315

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>705 Greentree Road</u>		d. STREET ADDRESS <u>705 Greentree Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Sophia</u> Middle <u>Coliano</u> Last		4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/12/1898</u>
9. AGE (in years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Luciano Raimondi</u>		14. MOTHER'S MAIDEN NAME <u>Rose Sylvestri</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Angelo P. Coliano</u>	
17. INFORMANT <u>(Same)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive acute myocardial infarction</u> DUE TO (b) <u>infarction</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>12.30</u> to <u>12.30</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>12.30</u> , 19 <u>67</u> , and that death occurred at <u> </u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Stanley Ankudas</u> M.D.		22b. DATE SIGNED <u>12.67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Stanley Ankudas</u>		22d. ADDRESS <u>1101 Maiden Chaise Lane</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/1/1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co. 4905 York Road 21212</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 2 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>Julian Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16324		16316	
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Annapolis</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holly Pt. Annapolis Roads</u>		2. USUAL RESIDENCE (Where deceased lived, in institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Annapolis</u> d. STREET ADDRESS <u>Holly Pt. Annapolis Roads</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jean M. Creighton</u>		4. DATE OF DEATH Month Day Year <u>Dec. 11 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 2, 1883</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Ontario, Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hugh MacKinnon</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>A. Graham Creighton</u>	
17. INFORMANT <u>A. Graham Creighton</u>		Address <u># 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u> <u>15 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 12, 1966</u> to <u>DEC 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 1967</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward S. Beck</u>		22b. DATE SIGNED <u>12-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>		22d. ADDRESS <u>FRANKLIN ST. ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-13-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove</u>	23d. LOCATION (City, town or county) (State) <u>New London Conn.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis, Md.</u>		25. REC'D BY REGISTRAR <u>DEC 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

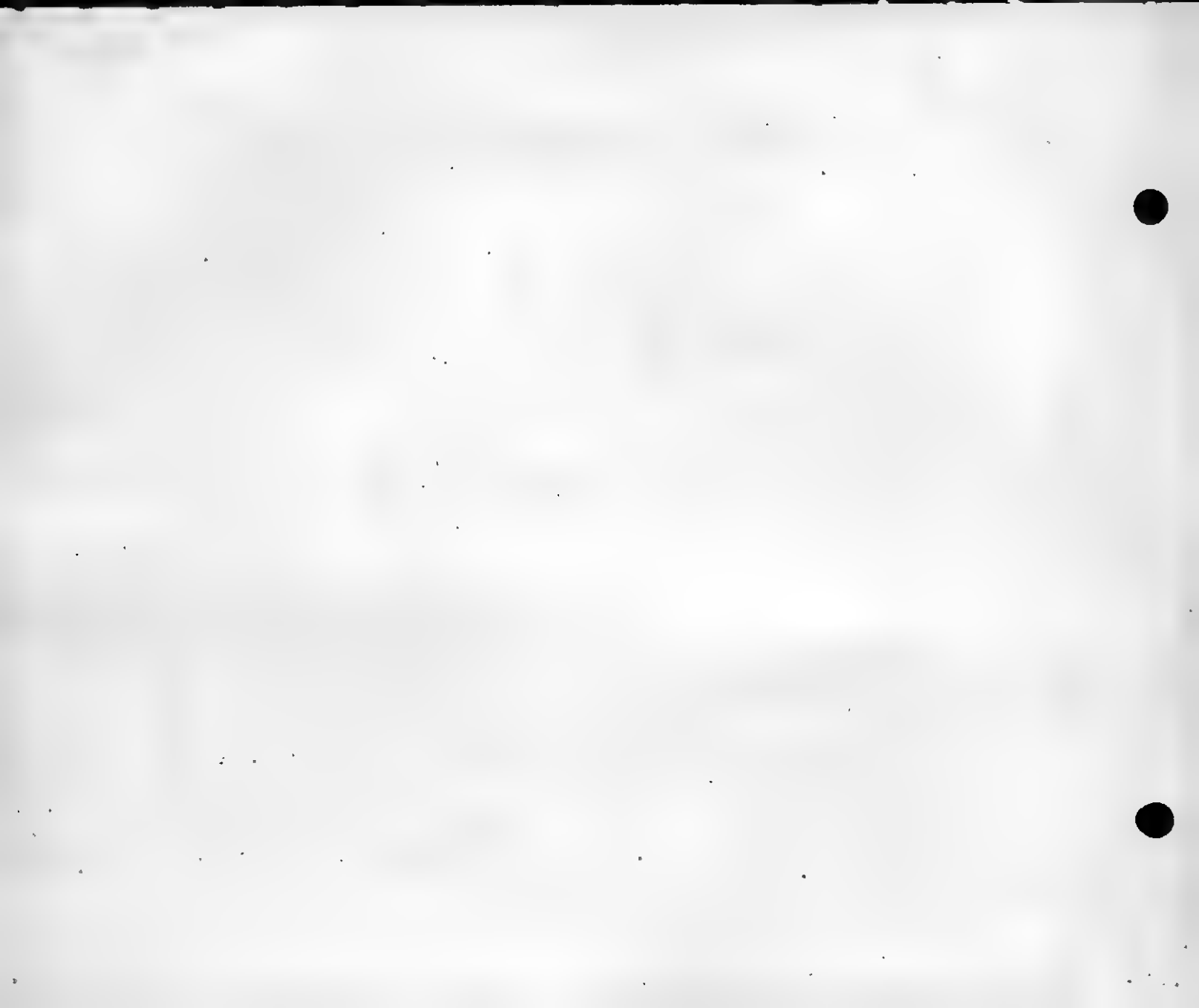
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 16317											
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>---</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Laurel Ridge Inn</u>					d. STREET ADDRESS <u>702 Stamford Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lee</u> Last <u>Cummins</u>					4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1967</u>						
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/28/17</u>		9. AGE (In years last birthday) <u>50</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chuck wagon, Inc.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Late - Albert Cummins</u>					14. MOTHER'S MAIDEN NAME <u>Late Frances Koska</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>383-18-1273</u>		17. INFORMANT <u>Ervin Cummins</u>			Address <u>203 5th Ave.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Choke</u> <u>4344</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>---</u> DUE TO (c) <u>---</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Choke</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>12</u> <u>00</u> p. m. <u>1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Laurel Ridge Inn</u>		20f. (City or town) <u>Towson</u>		(County) <u>Harford</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>E. L. W. H. B. R. D.</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
EXAMINER'S NAME (Type) <u>E. L. W. H. B. R. D.</u>					DATE SIGNED <u>12/23/67</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/27/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		(State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hitzke F. D. - 4101 Edmondson Ave.</u>					24a. REC'D BY REGISTRAR <u>DEC 26 1967</u>		24b. REGISTRAR'S SIGNATURE <u>---</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16326
10318
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold, Md. c. LENGTH OF STAY IN ID		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY 11 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARNOLD, MD d. STREET ADDRESS 402 Naskell DR e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Josephine First Dameron Middle Last		4. DATE OF DEATH Dec. 22 Month 1967 Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/16/1913
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) VA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Perry MANESS		14. MOTHER'S MAIDEN NAME Polly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Family		Address Sore	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the stomach DUE TO (b) 1 year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Mar. 16 , 19 64 , to Dec. 22 , 19 67 , that (I) (we) last saw the deceased alive on Dec 22 , 19 67 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Ray m Smith		22b. DATE SIGNED Dec 22, 1967	
22c. PHYSICIAN'S NAME (Type) Ray m. Smith, M.D.		22d. ADDRESS Hahn Professional Bldg., Severna Park Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 12-23-67	23c. NAME OF CEMETERY OR CREMATORY Lee Cem.	23d. LOCATION (City, town or county) (State) Nash. D.C.
24. FUNERAL DIRECTOR John H. Hahn		25a. REC'D BY REGISTRAR	
ADDRESS 4200 Pennington Rd. Baltimore 21226, Md.		25b. REGISTRAR'S SIGNATURE John H. Hahn	
DATE DEC 26 1967			



CERTIFICATE OF DEATH

16327

16319

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 43 Murray Avenue	
3 NAME OF DECEASED (Type or print) First Middle Last Theodore John DEMAS		4 DATE OF DEATH Month Day Year December 18 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1903
9. AGE (in years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) self employed		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (County & State, or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Demas		14. MOTHER'S MAIDEN NAME Evangeline Demas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 217-32-9144	
17. INFORMANT Chris Demas		Address 43 Murray Ave. Anna.Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral of Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 12/17 DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/1/65 , 19 65 , to 12/17 , 19 67 , that (I) (we) last saw the deceased alive on 12/17/67 , 19 67 , and that death occurred at 12:45 P.M. from causes and on the date stated above			
22a. SIGNATURE James B. Burch		22b. DATE SIGNED 12/19/67	
22c. PHYSICIAN'S NAME (Type) Barbara Chualet		22d. ADDRESS 121 EASTBONNET ST ANNAPOLIS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 20 1967	23c. NAME OF CEMETERY OR CREMATORY St. Demetrius Cem.	23d. LOCATION (City or Town) (County) (State) Annapolis, Anne Arundel Md
24. FUNERAL DIRECTOR Beall Funeral Home		25a. REC'D BY REGISTRAR DEC 22 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

VR A15 (4)
25M 1/67

should

MEDICAL CERTIFICATION

16323

Item #36 Film #33-4-30/177-2b DEATH

CERTIFICATE OF DEATH

16320

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>MD.</i>		b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Annapolis</i>		c. LENGTH OF STAY in 1b <i>27 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Annapolis</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Southaven Rd.</i>				d. STREET ADDRESS <i>Southaven Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Henry</i>		First <i>Henry</i>		Middle <i>Pi Benio</i>		Last <i>Pi Benio</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2/13/11</i>	
9. AGE (In years last birthday) <i>56 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (County & State, or foreign country) <i>New York State</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Felix Pi Benio</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>MRS. PI BENIO</i>		Address <i>As 2600</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic Heart Failure</i> DUE TO (b) <i>Hypertensive Arteriosclerotic CV Disease</i> DUE TO (c) <i>many years</i>						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Obesity</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>67</i> , to <i>December</i> , 19 <i>67</i> , that (I) (<i>we</i>) saw the deceased alive on <i>11/15</i> , 19 <i>67</i> , and that death occurred at <i>10A</i> M, from causes and on the date stated above							
22a. SIGNATURE <i>Robert O. Biern</i>				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>12/5/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert O. Biern, M.D.</i>				22d. ADDRESS <i>121 Cathedral Street, Annapolis, Md.</i>			
23a. BURIAL, CREMATON, REMOVAL (Specify) <i>Buried</i>		23b. DATE THEREOF <i>12/17/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Centerville Cemetery</i>		23d. LOCATION (City or town) (County) (State) <i>Centerville Queen Anne's Md</i>	
24. FUNERAL DIRECTOR <i>Hartshorn Funeral Home, Annapolis Md.</i>				25a. REC'D BY REGISTRAR DATE <i>DEC 7 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. [illegible]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

16323

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film # 3295 32/25/67 ph

CERTIFICATE OF DEATH

16321

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arnold Community Hm</u>		d. STREET ADDRESS <u>Camphead Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>W</u> Last <u>Desney</u>		4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/9/91</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Rds. Comm</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Severn, AA Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George P. Disney</u>		14. MOTHER'S MAIDEN NAME <u>Ida E. Beasley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Chart North Arnold C.C.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mediastinal Syndrome</u> DUE TO <u>Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/10/67</u> , 19 <u>67</u> , to <u>12/19/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/15/67</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. B. RAMIREZ</u>		22b. DATES SIGNED <u>12/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. B. Ramirez</u>		22d. ADDRESS <u>325 Hospital Drive Severn</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>22 Dec. 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sulphur Spring Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Ft. Meade, Maryland</u>
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 22 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16330

CERTIFICATE OF DEATH

16322

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General Hospital		d. STREET ADDRESS Waysons Restaurant	
3 NAME OF DECEASED (Type or print) First Loren Middle Charley Last DOTY		4 DATE OF DEATH Month December Day 27 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 4, 1906
9 AGE (In years last birthday) 61 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNK.	
10b KIND OF BUSINESS OR INDUSTRY ---		11 BIRTHPLACE (County & State or foreign country) Kansas	
12 CITIZEN OF WHAT COUNTRY? U.S.		13 FATHER'S NAME Charles Doty	
14 MOTHER'S MAIDEN NAME Anna Bell		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) UNK.	
16 SOCIAL SECURITY NO.		17 INFORMANT Hospital Records Address Annapolis, Md.	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 434.1 Congestive heart failure DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH 6 mos.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Waldenström's Macroglobulinemia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/67 , 19 to 12/27 , 19, that (I) (we) last saw the deceased alive on 12/25 , 19 67 , and that death occurred at 7:00 M, from causes and on the date stated above.			
22a. SIGNATURE Richard N. Peeler		22b. DATE SIGNED 12/27/67	
22c. PHYSICIAN'S NAME (Type) Richard N. Peeler, M.D.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 12-30-67	23c. NAME OF CEMETERY OR CREMATORY Graceland Cemetery	23d. LOCATION (City or Town) (County) (State) Madison S. Dakota
24. FUNERAL DIRECTOR John M. Layla & Sons		25a. REC'D BY REGISTRAR Annapolis, Md.	
25b. REGISTRAR'S SIGNATURE		DATE UEC 2.9 1987	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16331

16323

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u></u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>1 month</u>				d. STREET ADDRESS <u>3662 Weswick Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>N. Arundel Conv. Center</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SARA C. Downey</u>		First Middle Last		4. DATE OF DEATH <u>12 28 1967</u>		Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 18 1911</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY Musgrove</u>				14. MOTHER'S MAIDEN NAME <u>LEURA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>John H Downey Glen Burnie</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Retroperitoneal tumor</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>					
20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/18/1967</u> to <u>12/28/1967</u> , that (I) (we) last saw the deceased alive on <u>12/28/1967</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edmond F. Moushaker</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDMOND F. MOUSHAKER</u>				22d. ADDRESS <u>SID HARLEY STATION ROAD GLEN BURNIE, MD 21061</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-30-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ways Chapel</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR <u>Burgess Funeral Home Baltimore Md</u>				25a. REC'D BY REGISTRAR <u>JAN 2 1968</u> 25b. REGISTRAR'S SIGNATURE <u>r. b. yudge</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16332

CERTIFICATE OF DEATH

16324

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	c LENGTH OF STAY IN 1b <u>6 hours</u>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d STREET ADDRESS <u>855 Cottonwood Drive</u>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <u>Eva L. Drankwicz</u>		4 DATE OF DEATH Month Day Year <u>December 28 1967</u>	
5 SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10-19-03</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>@ home</u>	11 BIRTHPLACE (County & State, or foreign country) <u>Mississippi</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13 FATHER'S NAME <u>Michael W. Wierski</u>	
14. MOTHER'S MAIDEN NAME <u>Theodore Crown</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO <u>—</u>		17 INFORMANT <u>Mrs. Regina Loy-Above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Left Ventricular Failure</u> DUE TO <u>Essential Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>710 yrs</u> (c) <u>710 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>710 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>12-28</u> , 19 <u>67</u> to <u>12-28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-28</u> , 19 <u>67</u> , and that death occurred at <u>5:15</u> M, from causes and on the date stated above.	
22a. SIGNATURE <u>Hilary T. O'Herlihy</u>		22b. DATE SIGNED <u>12-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Hilary T. O'Herlihy</u>		22d. ADDRESS <u>Medical Center-Hospital Drive-Glen Burnie</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE OF REMOVAL <u>12/30/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie Md</u>	
24. FUNERAL DIRECTOR <u>Robert S. Baranov</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 2 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Robert S. Baranov</u>		25c. REGISTRAR'S SIGNATURE <u>Robert S. Baranov</u>	

CERTIFICATE OF DEATH

16333

16325

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 021		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS Annapolis, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) JOHN	First JOHN	Middle ADAM	Last DRUMM, JR.
4 DATE OF DEATH Month December	Day 13	Year 19 67	
5 SEX Male	6. COLOR OR RACE Cauc.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 August 1926
9 AGE (In years lost birthday) 41 yrs		IF UNDER 12 MONTHS Months 41	IF UNDER 24 HRS Days 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.F.C.		10b. KIND OF BUSINESS OR INDUSTRY MO. NAT'L. GAURD	11 BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN A. DRUMM, SR.	
14. MOTHER'S MAIDEN NAME FRANCES LOUISE CLARK		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II	
16. SOCIAL SECURITY NO 216 20 0119		17. INFORMANT MRS. HILOEGARDE A. DRUMM (WIFE) SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic Heart Disease (c) Ventricular Fibrillation			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10 Dec. , 19 67 to 13 Dec. , 1967, that (I) (we) last saw the deceased alive on 13 Dec. , 19 67 and that death occurred at 1130 M, from causes and on the date stated above.			
22a. SIGNATURE B. J. COUGHLIN		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) B. J. COUGHLIN, LT MC USNR		22d. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF DEC. 18/67	23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) GLEN BURNIE, MARYLAND
24. FUNERAL DIRECTOR - P. J. Singleton		25a. REC'D BY REGISTRAR DEC 19 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <div>16334</div> <div>1</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> <div> <div>16326</div> <div>2</div> </div> </div>									
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN ID MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2107 Dorsey Road					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie d. STREET ADDRESS 2107 Dorsey Road 21061 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Lizzie Middle E. Last Durham		4. DATE OF DEATH Month December Day 4 Year 1967		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Six Mile South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Garrett				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Earl Griffin 2107 Dorsey Road 21061 Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular accident DUE TO (b) A. S. C. V. D. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1963 , 19 to 1967 , that (I) (we) last saw the deceased alive on Dec. 4 1967 , and that death occurred at 8 AM , from the causes and on the date stated above.									
22a. SIGNATURE Robert Dabolins								22b. DATE SIGNED 12-5-67	
22c. PHYSICIAN'S NAME (Type) Robert Dabolins - M.D.				22d. ADDRESS 4700 Chain Hwy. T. 20					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/7/67		23c. NAME OF CEMETERY OR CREMATORY Six Mile Baptist Cemetery		23d. LOCATION (City, town or county) (State) Six Mile, S.C.			
24. FUNERAL DIRECTOR McCauley Funeral Home ADDRESS 237 Patapsco Ave.				25a. REC'D BY REGISTRAR DEC 6 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #3 Film #3396 12/3/68 ph

CERTIFICATE OF DEATH

16335

16327

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		d. STREET ADDRESS <u>116 Carroll Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Convalescent Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Albert Roy Ellis</u>		4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 1, 1882</u>
9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C & P Telephone</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>John F. Ellis</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Sherwood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO <u>212-10-0793A</u>	
17. INFORMANT <u>MR Charles L. Ellis (Nephew)</u>		Address <u>24 Love Lane Norwood, Penna</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>October, 1959</u> to <u>Dec.</u> , 1967, that (I) (<u>was</u>) lost saw the deceased alive on <u>12-27</u> , 19 <u>67</u> , and that death occurred at <u>12:15</u> A.M., from causes and on the date stated above			
22a. SIGNATURE <u>Edmond I. Moushabeck</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>EDMOND I. MOUSHABEK</u>		22d. ADDRESS <u>510 Maple Station Road Glen Burnie Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec 30, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR <u>E. B. Flinn</u>		25a. R.D. BY REGISTRAR DATE <u>DEC 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>W. J. Judge</u>		25c. REGISTRAR'S NAME <u>W. J. Judge</u>	



Item 9 Filed 1/2/68

16336

CERTIFICATE OF DEATH

16328

1 PLACE OF DEATH a. COUNTY <u>Ann Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Ann Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>313 Queestown Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Fred</u> First Middle Last <u>Evans</u>		4 DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-14-95</u> 9 AGE (In years last birthday) yrs <u>72</u>
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ISAIAH EVANS</u>		14. MOTHER'S MAIDEN NAME <u>ELLA BRACKSTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-05-2971</u>	
17. INFORMANT <u>MAURIE PARKER - SEVERN MD</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>A. S. C. V. D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 13</u> , 19 <u>67</u> , to <u>Dec 14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 14</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert Dabowski</u>		22b. DATE SIGNED <u>Dec 14, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT DABOWSKI MD</u>		22d. ADDRESS <u>400 CRAIN HWY NW GLEN BLINKIE MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>12-16-67</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR <u>William D. Byers</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 19 1967</u>	
ADDRESS <u>638 N. G. St</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #4 per telephone call w/ Dan Funeral Home											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY AA MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY AA					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKLYN PARK				c. LENGTH OF STAY IN 1b 7RS		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKLYN PARK					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 210 Holy Cross Road						d. STREET ADDRESS 210 Holy Cross Rd				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) ROY W. EVANS						4 DATE OF DEATH Month 12 Day 29 Year 1967					
5. SEX M		6 COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH OCT. 9, 1916		9. AGE (In years lost birthday) yrs 51		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY Heeg-Turnbull Co		11 BIRTHPLACE (County & State, or foreign country) Maryland				12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lawrence Evans						14 MOTHER'S MAIDEN NAME Sarah -					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES				16 SOCIAL SECURITY NO.		17. INFORMANT Family				Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Pancreas with DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis to liver. DUE TO (c)											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)						20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 3, 1967 , to Dec. 29, 1967 , that (I) (we) last saw the deceased alive on Dec. 29, 1967 , and that death occurred at 12 AM , from causes and on the date stated above											
22a SIGNATURE Morton M. Krieger						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b DATE SIGNED Dec 29, 1967	
22c PHYSICIAN'S NAME (Type) Morton M. Krieger, M.D.						22d ADDRESS 615 Hammonds Lane Balto. Md. 21225					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial				23b DATE THEREOF 1-2-68		23c NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem.				23d LOCATION (City or Town) (County) (State) Balto 21229, Md.	
24. FUNERAL DIRECTOR John H. Hahn Funeral Home - 4200 Pennsylvania Ave						25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

16336

CERTIFICATE OF DEATH

16330

1 PLACE OF DEATH a. COUNTY Ann Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE Md. b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 4402 Fairhaven Ave. Curtis Bay	
3 NAME OF DECEASED (Type or print) Marie H. Faby (MARRYANN)		4. DATE OF DEATH Month 12-19 Day 19 Year 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-21-20
9 AGE (In years last birthday) 47 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME KONSTANLEY ALEKSALZA		14. MOTHER'S MAIDEN NAME MARYANN MALINOWSKI	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17 INFORMANT EDW. FABY		Address 21206 4402 FAIRHAVEN AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Renal Failure DUE TO (b) Cirrhosis Liver DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-5-67, to 12-19-67, that (I) (we) last saw the deceased alive on 12-18-67, and that death occurred on 12-19-67, from causes and on the date stated above.			
22a. SIGNATURE Charles R. MacDonald M.D.		22b. DATE SIGNED 12-19-67	
22c. PHYSICIAN'S NAME (Type) Charles R. MacDonald M.D.		22d. ADDRESS 325 Hospital Drive Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12-23-67	23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEM.	23d. LOCATION (City or Town) (County) (State) BALTO. ANNE ARUNDEL, MD
24. FUNERAL DIRECTOR U. FIALKOWSKI 2007 EAST ANN AVE. BALTO., MD 21231		25a. REC'D BY REGISTRAR DEC 22 1967	
25b. REGISTRAR'S SIGNATURE James J. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16333

CERTIFICATE OF DEATH

16331

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY Ann Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Balto. County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN it 8 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Brooklyn Park)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 601 Holy Cross Rd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Wald First (son) Middle Fletcher Last		4. DATE OF DEATH Month 1-2 Day 25 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-29-94
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (Pipe-Fitter)		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad	9. AGE (In years and birthday) 72 yrs.
11. BIRTHPLACE (County & State, or foreign country) West Virginia (Grafton)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Fletcher		14. MOTHER'S MAIDEN NAME (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO 705-03-9577	
17. INFORMANT Mrs. Anna M. Fletcher (wife)		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 1 week
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 , to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 12:24 M, from causes and on the date stated above.			
22a. SIGNATURE Paul Abramson		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 28, 1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Singleton Funeral Home, Glen Burnie, Md.		25a. RECEIVED BY REGISTRAR DEC 28 1967 25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

VR A15 (4)
25M 1/67

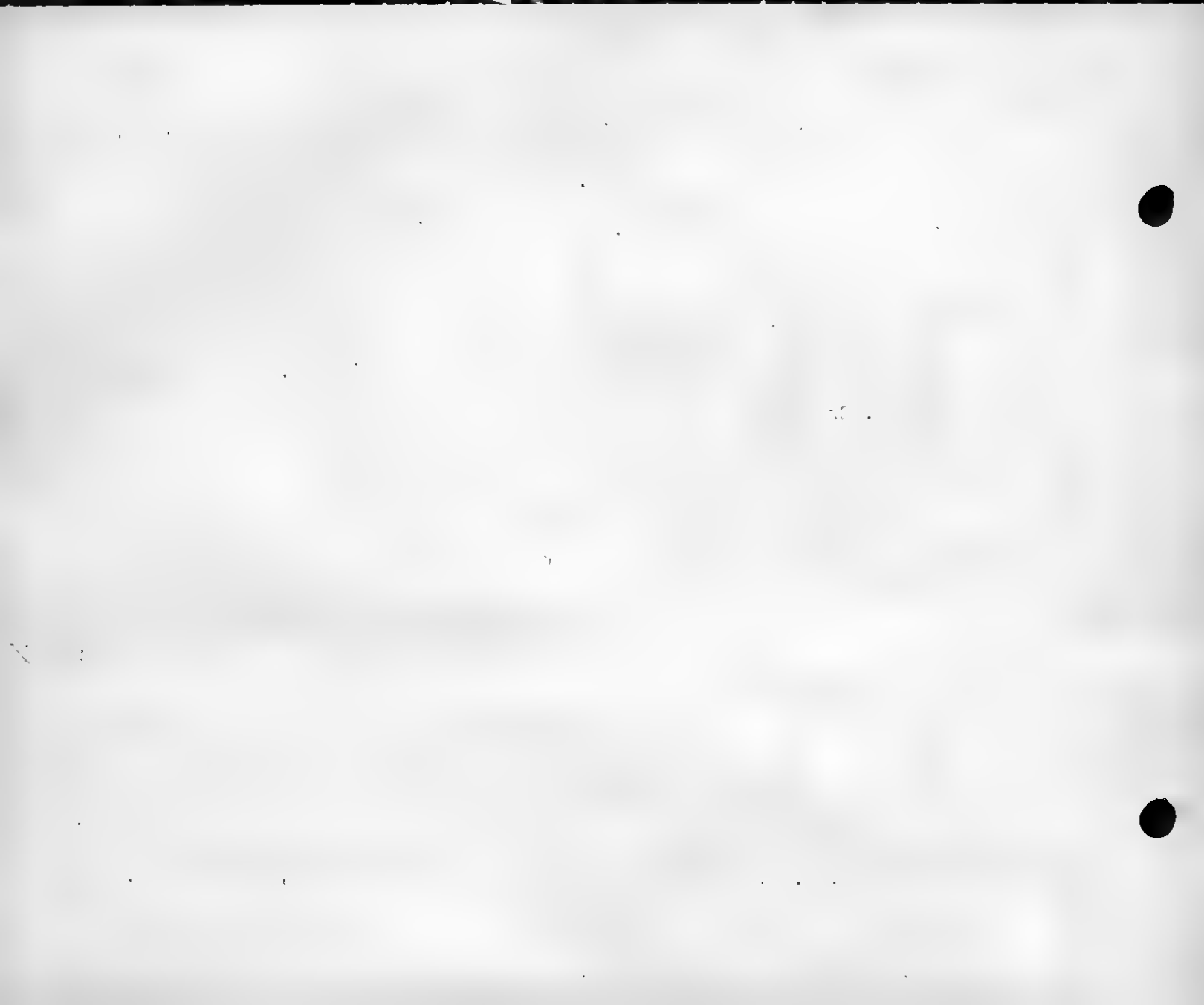
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16340

CERTIFICATE OF DEATH

16332

1. PLACE OF DEATH a. COUNTY Anne Arundel Annapolis MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b 8 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital, Annapolis, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ella Middle Mae Last Fogg		4. DATE OF DEATH Month 12 Day 18 Year 1967	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 8 1919
9. AGE (In years last birthday) 48 Yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James P. Crawford	
14. MOTHER'S MAIDEN NAME Agnes Carney		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. —		17. INFORMANT FRANK M. FOGG # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 110X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma breast DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. —	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 , 19 , that (I) (we) last saw the deceased alive on 18 December 1967 , and that death occurred at 1859 M. from causes and on the date stated above			
22a. SIGNATURE A. C. J. BRICKEL, LT MC USNR		22b. DATE SIGNED 12/19/67	
22c. PHYSICIAN'S NAME (Type) A. C. J. BRICKEL, LT MC USNR		22d. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE, THEREOF 12/23/67	23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEM.	23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD.
24. FUNERAL DIRECTOR JOHN M. TAYLOR & SONS, ANNAPOLIS, MD.		25a. REC'D BY REGISTRAR DEC 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 143. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16341

16333

1 PLACE OF DEATH a. COUNTY <u>B.A. CO.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, first if not Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA CO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN lb <u>Arden-on-Severn</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Minor Rd.</u>		d. STREET ADDRESS <u>Plum Dr + Minor Road</u>	
3 NAME OF DECEASED (Type or print) <u>Philip G. Fogler</u>		4. DATE OF DEATH Month <u>12</u> Day <u>30</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30, 1953</u>
9 AGE (In years last birthday) <u>14</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11 BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13 FATHER'S NAME <u>John W. Fogler</u>		14. MOTHER'S MAIDEN NAME <u>Lorraine E. Schaefer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mrs. Lorraine E. Fogler</u>	
17. INFORMANT <u>Same</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gun Shot Wound - Skull</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gun Shot Wound Skull - Accidental</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> PRIMARY <input type="checkbox"/> CONTRIBUTING		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Gun Shot Wound Skull - Accidental</u>	
20c. TIME OF INJURY Month Day, Year <u>12/30/1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>AA CO MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		22. DATE SIGNED <u>12/30/67</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		Address (Street, city, town, or county) <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1 3 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, A. A. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Mc Gully</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 3 1968</u>	
ADDRESS <u>130 E. Fort Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATE



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16342 CERTIFICATE OF DEATH 16334											
1. DECEASED NAME (Type or print) Davison			First Middle Last F. Gallagher			2a. DATE OF DEATH Month Day Year 12 25 67			2b. HOUR 8:25 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9/24/91		6. AGE (In years lost birthday) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Crownsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Construction Work			12b. KIND OF BUSINESS OR INDUSTRY		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1181/2 Camrose Street		
14. FATHER'S NAME First Middle Last Hugh Gallagher			15. MOTHER'S MAIDEN NAME First Middle Last Marry Stewart								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 216-03-0827		17. INFORMANT Address Hospital Records, Crownsville State Hospital						
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 475X DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic Brain Syndrome ; Generalized arteriosclerosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/5</u> , 19 <u>67</u> , to <u>12/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/25</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <u>L. Benedict, M.D.</u>				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/26/67			
22d. PHYSICIAN'S NAME (Type) L. Benedict, M.D.				22e. ADDRESS Crownsville State Hospital, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-29-1967		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hwy., Baltimore				ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 29 1967		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
USM 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16343

16335

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 1 Shipwright St.	
3 NAME OF DECEASED (Type or print) First Middle Last GAY		4. DATE OF DEATH Month Day Year December 24 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH December 24, 1967
9 AGE (In years last birthday) 13		10 IF UNDER 1 YEAR Months Days Hours Min 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11a. BIRTHPLACE (County & State or foreign country) Annapolis, Maryland		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Herold C. GAY		14. MOTHER'S MAIDEN NAME Julia Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO —	
17. INFORMANT A.C. GAY #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. 7735 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO (b) Pneumonia DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M. from causes and on the date stated above 2:30 P.M.			
22a. SIGNATURE James E. Wheeler		22b. DATE SIGNED 12-26-67	
22c. PHYSICIAN'S NAME (Type) James E. Wheeler, M.D.		22d. ADDRESS 308 S. Cherry Grove Ave., Annapolis, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 12-27-67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	23d. LOCATION (City or Town) (County) (State) BLADENSBURG MD.
24. FUNERAL DIRECTOR John M. Lafferty		25a. REC'D BY REGISTRAR DEC 28 1967	
25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16344

16336

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b Annopolis		2. USUAL RESIDENCE (Where deceased lived if institut on Residence before admiss an) a. STATE Maryland b. COUNTY 11	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hattie Green		4. DATE OF DEATH Month 12 Day 18 Year 1967	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/29/01
9. AGE (If years lost day) yrs 76		10. IF UNDER 1 YEAR Months Days Hours Mins. 12 18 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY retired	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Butler		14. MOTHER'S MAIDEN NAME Kate (?) Butler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 213-28-9924	
17. INFORMANT Hospital Records, Crownsville Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO (b) Hypertension DUE TO (c) Generalized arteriosclerosis			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pyelitis chronic brain syndrome			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/18 , 19 67 , to 12/18 , 19 67 , that (I) (we) last saw the deceased alive on 12/18 , 19 67 , and that death occurred at 1:30 a.m. , from causes and on the date stated above.			
22a. SIGNATURE Ludwig Benedict, M.D.		22b. DATE SIGNED 12/18/67	
22c. PHYSICIAN'S NAME (Type) Ludwig Benedict, M.D.		22d. ADDRESS Crownsville, State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/21/67	
23c. NAME OF CEMETERY OR CREMATORY Broadneck		23d. LOCATION (City or Town) (County) (State) St. Margarets P.A. Md	
24. FUNERAL DIRECTOR WM REESE II 108 N. WASHINGTON ST		25a. REC'D BY REGISTRAR DEC 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16345

16337

1. PLACE OF DEATH a. COUNTY Ann Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Ann Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS Rt. 4 Box 14 - Greenhaven	
3. NAME OF DECEASED (Type or print) Mabel R. Grimes		4. DATE OF DEATH Month 12 - Day 26 - Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-20-97
9. AGE (in years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months 12 Days 6 Hours 7 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vincent Tomlinson		14. MOTHER'S MAIDEN NAME Susan Hewitt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 215-32-8170	
17. INFORMANT Mrs. Anna Evered - Rt. 4, Box 14, Pasadena		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 12-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 14 days year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-25-1967 to 12-26-1967 , that (I) (we) lost saw the deceased alive on 12-25-1967 , and that death occurred at 2:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE Ailey Morley		22b. DATE SIGNED 12-26-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 29, 1967	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.	23d. LOCATION (City or Town) (County) (State) Ritchie Hwy., A.A. Co., Md.
24. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hwy., Baltimore		25a. REC'D BY REGISTRAR DATE DEC 29 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, please remove carbon pages 1, 2, and 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

16346

16338

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ben Burne Md.</u>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Glaze Manor Nursing Home</u>				d. STREET ADDRESS <u>Annapolis 818 Spa Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Charles Edward Hall</u>				4. DATE OF DEATH <u>12-20-1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-18-1905</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Co. Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Hall, Gordon</u>				14. MOTHER'S MAIDEN NAME <u>Peters, Sarah</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>217-16-4339</u>			
17. INFORMANT <u>Blanche A. Hall</u> Address <u>818 Spa Rd.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Sclerosis</u> (a), stating the underlying cause last. DUE TO (c) <u>Arterial Sclerosis</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-26-1967</u> to <u>12-20-1967</u> that (I) (we) last saw the deceased alive on <u>12-20-1967</u> , and that death occurred at <u>9:40</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Hunt</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Hunt</u>				22d. ADDRESS <u>107 Cherry Lane, Towson, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>12-23-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Prose</u> ADDRESS <u>Annapolis Md.</u>				25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u>			
DATE <u>DEC 27 1967</u>							

CERTIFICATE OF DEATH

16339

1634

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS Rt-416	
3. NAME OF DECEASED (Type or print) First Frank Middle Edward Last HALL, Sr.		4. DATE OF DEATH Month December Day 28 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1895
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Mins 0	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Albert Hall		14. MOTHER'S MAIDEN NAME Mary Hall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 519-40-31159	
17. INFORMANT Mary Hall Lathian, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of right lung DUE TO (b) — DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH One year	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		9. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (we) attended the deceased from June , 19 67 , to Dec. 28 , 19 67 , that (I) (we) last saw the deceased alive on Dec. 28 , 19 67 , and that death occurred at — M, from causes on and on the date stated above.			
22a. SIGNATURE Charles H. Wirth, M.D.		22b. DATE SIGNED 12/30/67	
22c. PHYSICIAN'S NAME (Type) Charles H. Wirth, M.D.		22d. ADDRESS Portland Place, Lothian, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/31/67	23c. NAME OF CEMETERY OR CREMATORY Adams	23d. LOCATION (City or Town) (County) (State) Bayfield, Md.
24. FUNERAL DIRECTOR William Reese, Jr., Annap., Md.		25a. REC'D BY REGISTRAR DATE JAN 2 1968	
		25b. REGISTRAR'S SIGNATURE W. J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1634

16340

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RJR and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis,	
c. LENGTH OF STAY IN it 15 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 916 Central		d. STREET ADDRESS 916 Central	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William NMN Harris Harrod		4. DATE OF DEATH Month December Day 10 Year 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-1881
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Naval Academy	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wesley Harris		14. MOTHER'S MAIDEN NAME Sarah J. Reid	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No *****		16. SOCIAL SECURITY NO. 220-24-8169	
17. INFORMANT Mary E. Swann Harris		Address Annapolis, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Delirium, Generalized DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic Ca of Liver DUE TO Prostatic Cancer (c) 		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Pyelonephritis, Chronic Brain Syndrome.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from SEPT. 28, 1967 , to DEC. 10, 1967 , that (I) () last saw the deceased alive on DEC. 9, 1967 , and that death occurred at 7:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Richard E. Cook M.D.		22b. DATE SIGNED 12/10/67	
22c. PHYSICIAN'S NAME (Type) Richard E. Cook, M.D.		22d. ADDRESS 20 DEAN STREET, ANNAP., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-13-67	23c. NAME OF CEMETERY OR CREMATORY Brewer Hill	23d. LOCATION (City or Town) (County) (State) Annapolis A.A.Co Md
24. FUNERAL DIRECTOR C.E. Hicks, III		25a. REC'D BY REGISTRAR DEC 14 1967	
ADDRESS Annapolis, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c LENGTH OF STAY IN 1b Annapolis	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 20 Thompson St.,	
3 NAME OF DECEASED (Type or print) Ethel LARZELERE HERRIES		4. DATE OF DEATH Month December Day 5 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1886
9 AGE (in years last birthday) yrs. 81		IF UNDER 1 YEAR Months 5 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11 BIRTHPLACE (County & State, or foreign country) Buff Pto New York		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HERMAN LARZELERE		14. MOTHER'S MAIDEN NAME MARY WHITNEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO #2	
17. INFORMANT J. WHITNEY HERRIES		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ANEMIA, UREMIA			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 DEC 19 67 to Dec. 5, 19 67 that (I) (the) last saw the deceased alive on Dec. 5, 19 67 , and that death occurred at 1230 P.M. from causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck		22b. DATE SIGNED 12-6-67	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.		22d. ADDRESS 73 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-8-67	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION (City or Town) (County) (State) Annapolis AA. MD.	
24. FUNERAL DIRECTOR John M. Lyons		25a. REC'D BY REGISTRAR DEC 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

CERTIFICATE OF DEATH

16341

16341

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 146 Monticello Ave.,	
3. NAME OF DECEASED (Type or print) First James Middle Robert Last HERRON		4. DATE OF DEATH Month December Day 20 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1898
9. AGE (In years lost birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 20 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NAVAL ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE	
11. BIRTHPLACE (County & State, or foreign country) LAURINBURG (North Carolina)		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ALEXANDER HERRON		14. MOTHER'S MAIDEN NAME LUCY ABERNETHY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wrot. or dates of service) YES WWI		16. SOCIAL SECURITY NO. 257 109105	
17. INFORMANT CORNELIA C. HERRON #2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERITONITIS, diffuse, extensive DUE TO (b) Post-operative ileus and infection DUE TO (c) Primary Carcinoma of Rectum	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Secondary anemia and malnutrition		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Nov. 15, 1967 to Dec. 20, 1967 , that (I) was saw the deceased alive on Dec. 20, 1967 , and that death occurred at 9:00 AM from causes and on the date stated above.			
22a. SIGNATURE Merton T. Waite		22b. DATE SIGNED 12-20-67	
22c. PHYSICIAN'S NAME (Type) Merton T. Waite, M.D.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-23-67	
23c. NAME OF CEMETERY OR CREMATORY ELMWOOD		23d. LOCATION (City or Town) (County) (State) CHARLOTTE N.C.	
24. FUNERAL DIRECTOR John M. L. Taylor Annapolis, Md.		25a. REC'D BY REGISTRAR DEC 26 1967	
25b. REGISTRAR'S SIGNATURE John Charles Judge			

16350

16342

C2-1

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16351

CERTIFICATE OF DEATH

16343

1. PLACE OF DEATH a COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>161 Main Street</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Walter A. HIPKINS</u>				4 DATE OF DEATH Month <u>December</u> Day <u>31</u> Year <u>1967</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>October 1, 1893</u>		9 AGE (in years last birthday) <u>74</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLEAN RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETAIL PAINT</u>		11 BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13 FATHER'S NAME <u>JOHN C. HIPKINS</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH BROOKS</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17 INFORMANT <u>MRS. HELEN J. FORD Riverdale Rd. 4519</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO (b) <u>Chronic obstructive Pulmonary Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 Months</u> <u>15 Yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Fibrosis; Emphysema</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>the hospital</u> attended the deceased from <u>June 1, 1958</u> , to <u>Dec. 31, 1967</u> , that (I) <u>never</u> last saw the deceased alive on <u>31 Dec 1967</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Edward S. Beck, M.D.</u>				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>12-31-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward S. Beck, M.D.</u>				22d. ADDRESS <u>73 Franklin Street, Annapolis, Md.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>1-3-1968</u>		23c NAME OF CEMETERY OR CREMATORY <u>ST. ANNE'S CEM.</u>		23d LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD</u>	
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR, 301 W ANNAPOLIS MD</u>				25a REC'D BY REGISTRAR DATE <u>1 JAN 4 1968</u>		25b REGISTRAR'S SIGNATURE <u>William J. Judge</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16352

16344

1 PLACE OF DEATH a. COUNTY <u>HANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Annapel Convalescent Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>MATTIE E HOLT</u>		4 DATE OF DEATH <u>Dec 11 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-1883</u>
9. AGE (in years, lost birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County, State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Holt</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Holt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Leroy Evans Annand</u>		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Left Ventricular Failure</u> DUE TO (b) <u>Cerebrovascular accident</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Minutes</u> <u>Years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/29, 1967</u> to <u>12/11, 1967</u> that (I) (we) last saw the deceased alive on <u>12/11, 1967</u> , and that death occurred at <u>12:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Max C. Frank</u>		22b. DATE SIGNED <u>12/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MAX C FRANK</u>		22d. ADDRESS <u>425 SE Ritchie Hwy Glen Burnie, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<u>Burial</u>		<u>12-15-67</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)	
<u>Brewer Hill</u>		<u>Annapolis Md.</u>	
24. FUNERAL DIRECTOR <u>William Reese Jr.</u>		ADDRESS <u>Annapolis, Md.</u>	
25a. REC'D BY REGISTRAR <u>DEC 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jago</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
16353			
CERTIFICATE OF DEATH			
16345			
1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
c. LENGTH OF STAY IN 1b <u>1 Year</u>		d. STREET ADDRESS <u>650 Americana Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>650 Americana Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William A. HOVEMANN</u>		4. DATE OF DEATH <u>12-13-67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-20-81</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR: Months <u>12</u> Days <u>13</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jewelry</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Jewelry</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herman Hovemann</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Roemer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Severna Park, Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1956</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Generalized arteriosclerosis</u>	
(c) <u>—</u>		<u>1956</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>Previous Coronary Thrombosis 1956</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>Dec.</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>Nov.</u> , 19 <u>67</u> , and that death occurred at <u>5A</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Francis I. Codd</u> M.D.		22b. DATE SIGNED <u>12-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Francis I. Codd M.D.</u>		22d. ADDRESS <u>Severna Park, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>12-14-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lee Crematory</u>	23d. LOCATION (City or town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>Paul S. Baranco, Severna Park, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

16354

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

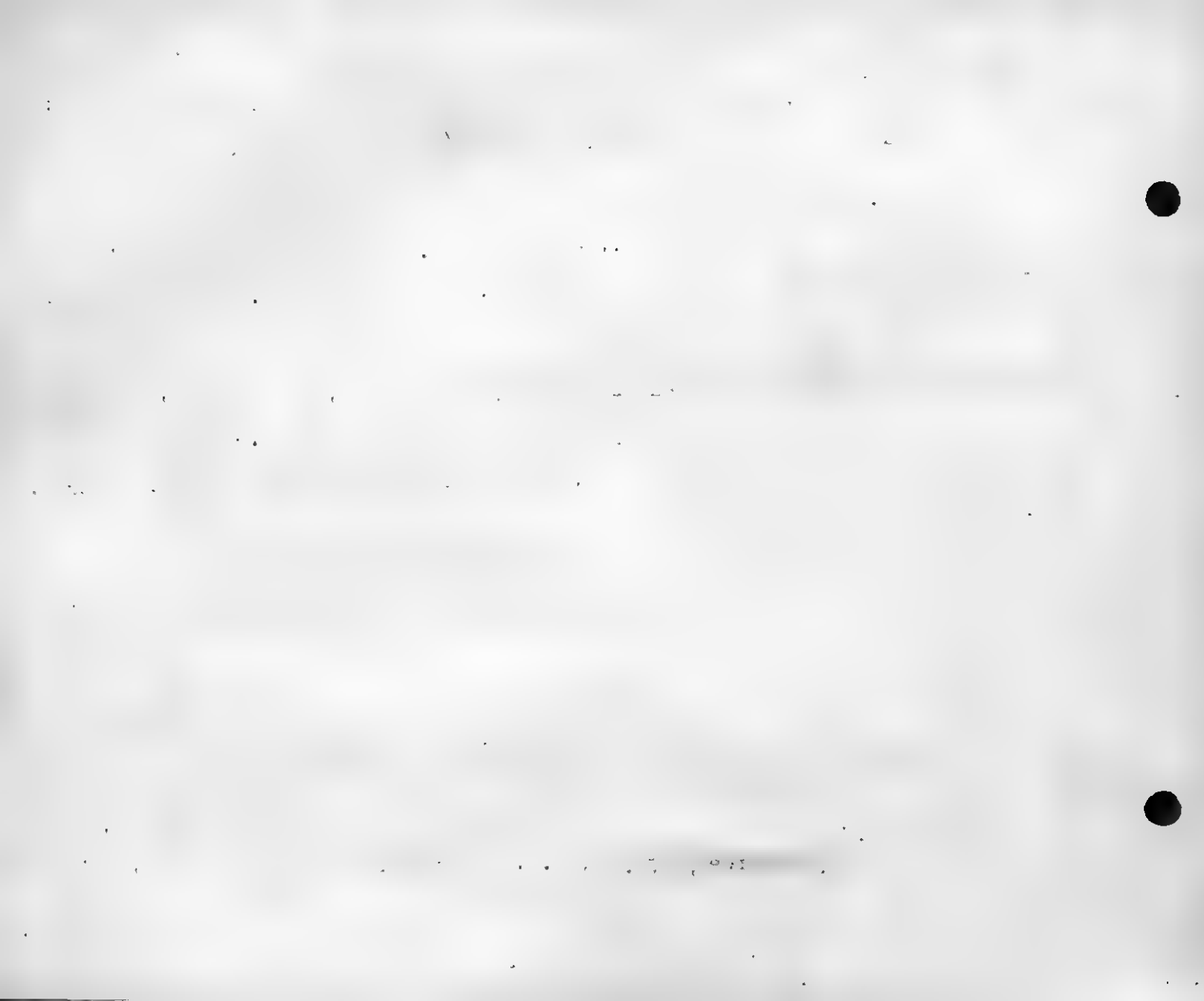
16346

1 PLACE OF DEATH a COUNTY <u>A. H. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD</u> b COUNTY <u>HARCO</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>		c LENGTH OF STAY IN 1b <u>Annopolis -</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS <u>Defense Highway</u>	
3 NAME OF DECEASED (Type or print) <u>Douglass Lee Hunt</u>		4 DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov 17, 1944</u>
9 AGE (In years last birthday) <u>23</u> yrs		10a USJA, OCC. PAT. ON (Give kind of work done during most of working life, even if retired) <u>SUBS. 10R</u>	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Annopolis, Md</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>Harold L. Hunt</u>	
14 MOTHER'S MAIDEN NAME <u>Ruth Luke</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOC. SEC. NO. <u>212-42-6858</u>		17 INFORMANT <u>Harold Hunt + Annopolis - Md</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gun shot wound chest</u> DUE TO (b) <u>776x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Gun shot wound chest</u>	
20c TIME OF INJURY Month, Day, Year hour <u>12</u> min <u>4</u> pm <u>12/19/67</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home farm factory street office bldg, etc.) <u>Home</u>		20f (City or town) (County) (State) <u>Annopolis HARCO MD</u>	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		22. DATE SIGNED <u>12-19-67</u>	
EXAMINER'S NAME (Type) <u>F. L. White</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a B. PAL. CREMA. OR REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>12/22/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		23d LOCATION (City or town) (County) (State) <u>Annopolis HARCO MD</u>	
24 FUNERAL DIRECTOR <u>TL Henderson</u>		25a REC'D BY REGISTRAR <u>Annopolis, Md</u>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>DEC 29 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Albert		Middle Jacobs		Last Jacobs		2a. DATE OF DEATH Month 12/29 Day 67 Year 1967	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 8/9/03			6 AGE (In years lost birthday) 64 YRS		2b. HOUR 1:30 PM	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Anne Arundel Md				
10. CITY OR TOWN OF DEATH Crownsville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1208 E. Baltimore Street	
14. FATHER'S NAME First Middle Last Charles K Jacobs			15 MOTHER'S MAIDEN NAME First Middle Last Margaret ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) YES USN			16b. SOCIAL SECURITY NO 188-20-2558		17 INFORMANT Hospital Records, Crownsville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardio vascular accident(right hemiplegia) 445 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) arteriosclerotic hypertension with vascular disease. DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 10/61, 19 61 to 12/29, 19 67, that (I) (we) last saw the deceased alive on 12/29, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Hildagarde Reissman, M.D.						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12/29/67		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Crownsville State Hospital, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Anatomy Board of Md.			23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 15 1968		25b. REGISTRAR'S SIGNATURE Hildagarde Reissman		



CERTIFICATE OF DEATH

16353

16347

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights		c. LENGTH OF STAY IN 1b Elkridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 407 Medora Road		d. STREET ADDRESS 5502 Main Street	
3 NAME OF DECEASED (Type or print) First Middle Last Bessie S. Janson		4 DATE OF DEATH Month Day Year 12 26 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/12/87
9 AGE (In years last birthday) yrs 80		10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William L. Rigby		14 MOTHER'S MAIDEN NAME Sallie E. Geddes	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO None	
17 INFORMANT Mr. Charles J. Janson, 407 Medora Rd. 21090		Address Linthicum Hgts.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 443 X IMMEDIATE CAUSE (a) Acute Left Ventricular Failure DUE TO (b) Hypertensive Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hours 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF DEATH Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from OCT 19 , 19 68 to 12/26 , 19 67 that (I) (we) last saw the deceased alive on DEC 19 , 19 68 , and that death occurred at 9 AM , from causes and on the date stated above			
22a. SIGNATURE Benjamin Berdann		22b DATE SIGNED 12/27/67	
22c. PHYSICIAN'S NAME (Type) Dr. Benjamin Berdann		22d. ADDRESS 615 Hammonds Lane A. A. Co.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/29/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24 FUNERAL DIRECTOR Howard H. Hubbard Funeral Home, 4107 Wilkens Ave.		25a REC'D BY REGISTRAR DEC 28 1967	
25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1-67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
16357		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
16348			
1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Mins.	
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital D.O.A.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - IOTHIAN	
3 NAME OF DECEASED (Type or print) JAMES WEBSTER JOHNSON		f. STREET ADDRESS Route 1 - Box 173	
4 DATE OF DEATH Month Dec. Day 10 Year 19 67		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 22-67
9 AGE (in years lost birthday) yrs 3 Months 12 Hours Min		10a. USUAL OCCUPATION (Give kind of work done during most of last year) ***** **	
10b. KIND OF BUSINESS OR INDUSTRY ***** **		11 BIRTHPLACE (State or foreign country) Calvert Co. Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME James W. Johnson Jr.	
14 MOTHER'S M maiden NAME Gladys Jenkins		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO *****		17 INFORMANT James W. Johnson Jr. Rt.1-Box173 P.O.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY 493X IMMEDIATE CAUSE (a) Memorized DUE TO (b) Cholesterol Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		19 INTERVAL BETWEEN ONSET AND DEATH Cholesterol	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY DESCRIBED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. ((City or town) (County) (State)
21. I certify that I took charge of the removals described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E.G. LINHARDT M.D.		22. DATE SIGNED 12-10-67	
EXAMINER'S NAME (Type) E.G. LINHARDT		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 12-67	23c. NAME OF CEMETERY OR CREMATORY MOSES	23d. LOCATION (City or town) (County) (State) DRUDY A.A.Co. Maryland
24 FUNERAL DIRECTOR C.E.Hicks 111 Annapolis, Maryland		25a. REC'D BY REGISTRAR DEC 14 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16353 CERTIFICATE OF DEATH 16349

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewater			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last Herbert JONES				4. DATE OF DEATH Month Day Year December 30 1967			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 3, 1915	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Osiah Jones				14. MOTHER'S MAIDEN NAME Bertha Spriggs			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 218-129821			
17. INFORMANT Address				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) massive cerebral hemorrhage DUE TO (b) severe hypertension DUE TO (c) severe hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) massive cerebral hemorrhage right side			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 1 year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from 19 to Dec 30, 1967, that (I) (we) last saw the deceased alive on 19, and that death occurred at 7:25 pm, from the causes and on the date stated above.							
22a. SIGNATURE Richard E. Cook				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-2-68	
22c. PHYSICIAN'S NAME (Type) Richard E. Cook, M.D.				22d. ADDRESS 20 Dean Street, Annapolis, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-4-1968		23c. NAME OF CEMETERY OR CREMATORY Hope Memorial		23d. LOCATION (City, town, or county) Edgewater (State)	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese				ADDRESS Anna		25a. REC'D BY REGISTRAR DATE JAN 4 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

16350

CERTIFICATE OF DEATH

16350

1 PLACE OF DEATH a COUNTY ANNE ARUNDEL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G. MEADE		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		d. STREET ADDRESS ROUTE #3, BOX 189	
3 NAME OF DECEASED (Type or print) First LEON Middle E. Last JONES		4 DATE OF DEATH Month DECEMBER Day 9 Year 1967	
5 SEX MALE	6 COLOR OR RACE NEGRO	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH OCT 24, 1946
9 AGE (In years lost birthday) yrs 21		10 IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army	
11. BIRTHPLACE (County & State, or foreign country) Ahoskie, N.C.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jessie Jones, Jr.		14 MOTHER'S MAIDEN NAME Annie E. Ruffin	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 23Mar66-9Dec67		16. SOCIAL SECURITY NO 230-66-6533	
17. INFORMANT Official military records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 057.1 IMMEDIATE CAUSE (a) BILATERAL PULMONARY MENINGOCOCCEMIA DUE TO (b) EDEMA OF ETIOLOGY TO BE DETERMINED DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH - 2 - 12 -	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21 I certify that (I have received from the deceased) XX the deceased XX was DOA XX on 9 DEC 1967 , that (I have received from the deceased) XX and that death occurred at 5:35 A.M. from causes and on the date stated above			
22a SIGNATURE Fredrick Shuster CPT MC		22b DATE SIGNED 9 DEC 67	
22c PHYSICIAN'S NAME (Type) FREDERICK SHUSTER, CPT, MC		22d ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 12/14/67	23c NAME OF CEMETERY OR CREMATORY Rosewell Cemetery	23d LOCATION (City or Town) (County) (State) Norfolk, Virginia
24 FUNERAL DIRECTOR HOWARD COUNTY		25b REGISTRAR'S SIGNATURE Funeral Home Harry Witzke Maryland	
ADDRESS Ellicott City		DATE DEC 14 1967	

16360

CERTIFICATE OF DEATH

16351

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A. A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Ind.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riviera Bch.</u>		c. LENGTH OF STAY IN 1b <u>30 mi</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>165 PARK RD. RIVIERA Bch. A.A. Co.</u>		d. STREET ADDRESS <u>1168 Washington Blvd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER E. KAMM</u>		4. DATE OF DEATH Month Day Year <u>Dec. 31 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/1893</u>
9. AGE (In years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Steel</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Kamm</u>		14. MOTHER'S MAIDEN NAME <u>Thanna ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>Ind.</u>	
17. INFORMANT <u>Louise Wandasiewicz</u>		Address <u>A.A. Co. 165 Park Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic cardiovascular</u> DUE TO (c) <u>Chronic</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jul.</u> , 1965, to <u>Dec. 31</u> , 1967, that (I) (we) last saw the deceased alive on <u>Dec. 30</u> , 1967, and that death occurred at <u>11:30 PM</u> , from causes on the date stated above.			
22a. SIGNATURE <u>S. J. Liu</u>		22b. DATE SIGNED <u>Jan. 8 1968</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. J. Liu</u>		22d. ADDRESS <u>5301 Hanford Rd. Balt. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Ind.</u>
24. FUNERAL DIRECTOR <u>John J. Cowan, Son, Inc. 901 Mallory St. Balt. Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 4 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16361

16353

1 PLACE OF DEATH a. COUNTY <u>AA CO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived; if institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA CO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - NORTH ARUNDL</u>		e. STREET ADDRESS <u>RL 11 - Box 61</u>	
3 NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>Leroy</u> Last <u>Kelley</u>		4 DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-12-1901</u>
9 AGE (In years past birthday) <u>62</u> yrs		F UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sign Artist</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11 BIRTH-PLACE (State or foreign country) <u>Pennsylvania</u>		12 CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13 FATHER'S NAME <u>George W. Kelley</u>		14 MOTHER'S MAIDEN NAME <u>Reath Mays</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>21122</u>	
17 INFORMANT <u>Mrs. Agnes C. Kelley Rt. 11 Box 61 Pasadena</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerosis generalis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above and on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Indetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Ward</u>		22. DATE SIGNED <u>12-7-67</u>	
EXAMINER'S NAME (Type) <u>E. L. Ward</u>		23. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>12/11/67</u>	
23c FUNERAL DIRECTOR <u>McCauley Funeral Home</u>		23d LOCATION (City or town) (County) (State) <u>Patapsco Ave. 21225</u>	
24 REC'D BY REGISTRAR <u>Charles Judge</u>		25b REC'D BY REGISTRAR <u>Charles Judge</u>	

16362

CERTIFICATE OF DEATH

16354

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Suburban		c LENGTH OF STAY IN lb 18 yrs.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 906 Victory Ave.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Ella E. Lanham		4 DATE OF DEATH Month Dec. Day 10, Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 26, 1888
9 AGE (In years last birthday) 79 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME William J. Ford		14 MOTHER'S MAIDEN NAME Ella Grant	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. None	
17 INFORMANT Mr. John Sedlmayer		Address 4713 Meist Drive (21206)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardio-vascular disease 4000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arterio-sclerotic heart disease DUE TO (c) Senile dementia			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 19 66 , to Dec. 10, 19 67 , that (I) (we) last saw the deceased alive on 12 - 6 - 19 67 , and that death occurred at 5 A M. from causes and on the date stated above.			
22a SIGNATURE Samuel Rubin M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Dec. 11, 1967
22c. PHYSICIAN'S NAME (Type) Samuel Rubin		22d. ADDRESS 201 E. Patapsco Ave. (21225)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 13, 1967	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d LOCATION (City or Town) (County) (State) Ritchie Hwy. A. A. Co., Md.
24. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hwy (21225)	25a REC'D BY REGISTRAR DATE DEC 13 1967
		25b. REGISTRAR'S SIGNATURE <i>Charles J. Gonce</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

16363

16355

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4 and 5 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		e. STREET ADDRESS 594 Manor Road	
3 NAME OF DECEASED (Type or print) Herbert		4. DATE OF DEATH Month 12 Day 31 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-8-98
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months 12 Days 31 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millwright		10b. KIND OF BUSINESS OR INDUSTRY Unknown Co	
11. BIRTHPLACE (County & State, or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Lappe		14. MOTHER'S MAIDEN NAME Elizabeth Gillilan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215091169	
17. INFORMANT Hazel Lappe -		Address Albany	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Left ventricular failure DUE TO (b) Acute myocardial Infarction DUE TO (c) hours		INTERVAL BETWEEN ONSET AND DEATH hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour o m p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov , 1967 to Dec 31 , 1967, that (I) (we) last saw the deceased alive on Dec 31 1967, and that death occurred at 4:10 M, from causes and on the date stated above.			
22a. SIGNATURE MAX C FRANK MD		22b. DATE SIGNED 12/31/67	
22c. PHYSICIAN'S NAME (Type) MAX C FRANK MD		22d. ADDRESS 425 SC Ritchie Hwy - Glen Burnie Md 21061	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1-3-68	23c. NAME OF CEMETERY OR CREMATORY Meadowridge	23d. LOCATION (City or Town) (County) (State) Dorsey Prince Georges Co Md
24. FUNERAL DIRECTOR Robert S. Barranco		25a. REC'D BY REG STRA JA 4 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge			

CERTIFICATE OF DEATH

16366

16356

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt-3, Box 98K	
3. NAME OF DECEASED (Type or print) Magdeline		4. DATE OF DEATH Month December Day 13 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1898
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Mahorney		14. MOTHER'S MAIDEN NAME Clara (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Curtis Dye; Rt. 2, Box 82; Edgewater, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) Arteriosclerosis DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
INTERVAL BETWEEN ONSET AND DEATH unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April , 19 63 , to August 17 , 19 67 , that (I) (we) last saw the deceased alive on August 17 , 19 67 , and that death occurred at 8:45 AM , from causes and on the date stated above.			
22a. SIGNATURE Wm. P. Stephens		22b. DATE SIGNED 12-13-67	
22c. PHYSICIAN'S NAME (Type) William P. Stephens, MD.		22d. ADDRESS 38 Cornhill St., W. M. W. W. W. W. W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 15, 1967	23c. NAME OF CEMETERY OR CREMATORY Beulah Baptist Cem.	23d. LOCATION (City or Town) (County) (State) Fairfax Co., Va.
24. FUNERAL DIRECTOR Ives Funeral Home 2847 Wilson Blvd. Arlington, Virginia		25a. REC'D BY REGISTRAR DATE DEC 19 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. J.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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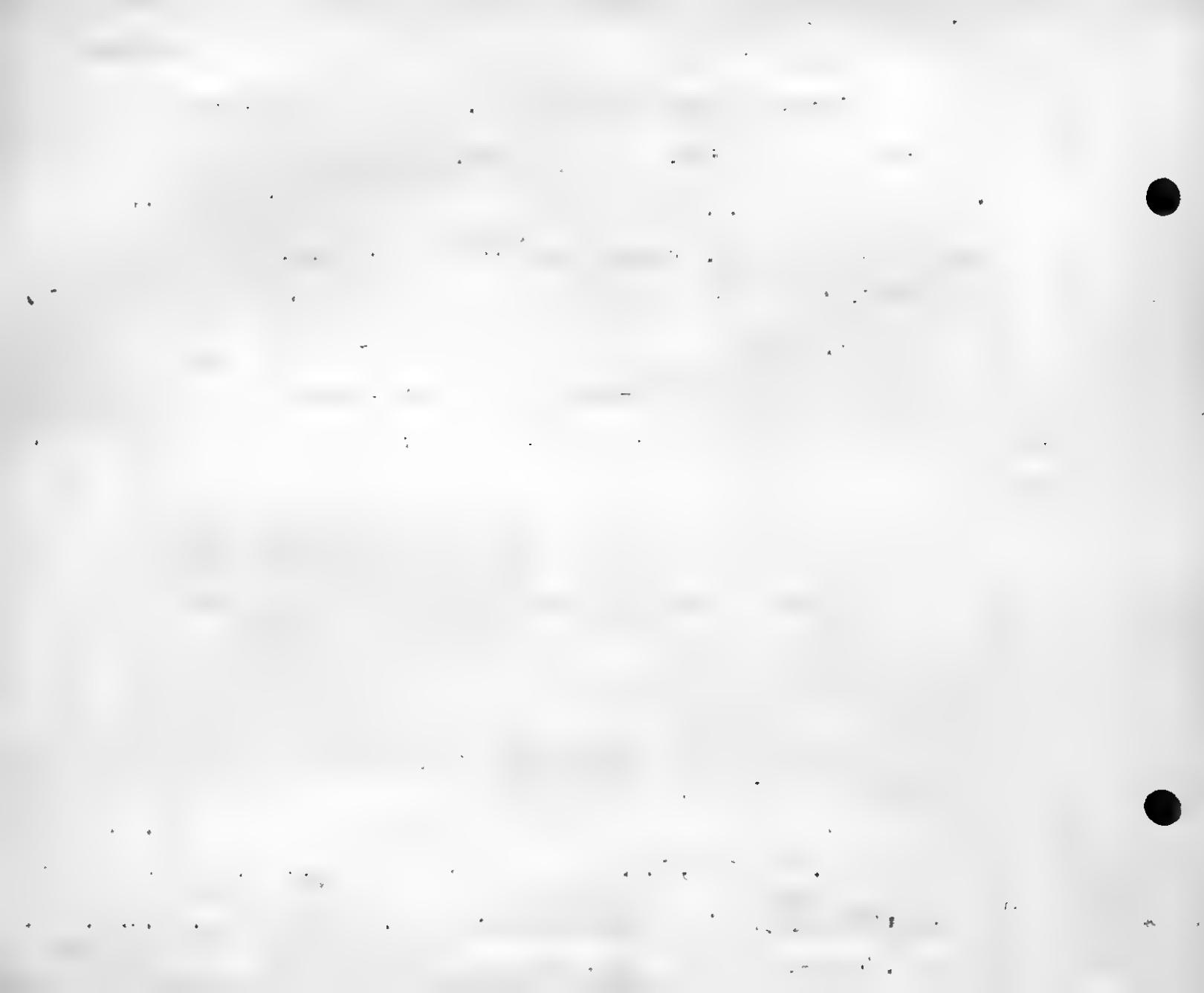
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital						d. STREET ADDRESS 123 Cathedral St.					
3 NAME OF DECEASED (Type or print) First Joseph Middle (none) Last LEVY						4 DATE OF DEATH Month December Day 15 Year 19 67					
5. SEX Male		6. COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Oct. 5, 1886		9 AGE (In years lost birthday) yrs 81		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) proprietor				10b KIND OF BUSINESS OR INDUSTRY retail dress		11 BIRTHPLACE (County & State, or foreign country) Baltimore City, Maryland				12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME David Levy						14 MOTHER'S MAIDEN NAME unknown					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 215-16-5735		17. INFORMANT Rose Goldberg Levy - same as #2 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prolonged illness DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Perforated Duodenal Ulcer DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21 I certify that (I) (the hospital) attended the deceased from Dec. 15, 1967 , to Dec. 15, 1967 , that (I) did last saw the deceased alive on Dec. 15, 1967 , and that death occurred at 9:38 AM M, from causes on and on the date stated above											
22a SIGNATURE Stephen B. Hiltabidle						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Dec 15 67			
22c. PHYSICIAN'S NAME (Type) Stephen B. Hiltabidle, M.D.						22d ADDRESS 121 Cathedral St., Annapolis, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 12/17/67		23c. NAME OF CEMETERY OR CREMATORY Kneseth Israel Cemetery				23d LOCATION (City or Town) (County) (State) Annapolis A.A. Md.			
24. FUNERAL DIRECTOR Beverley E. Hopping HOPPING FUNERAL HOME - Annapolis, Md.						25a. REC'D BY REGISTRAR DEC 18 1967		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) Margaret Mary Lewis (Mary M.)						2a. DATE OF DEATH Month December Day 31 Year 1967			2b. HOUR M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Jan. 18, 1911		6. AGE (In years last birthday) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Nebraska		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Co., Md					
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Center N. Arundel Convalescent		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. 1, Box 41 (Pinehurst)			
14. FATHER'S NAME First John A. Middle McNelis Last 				15. MOTHER'S MAIDEN NAME First Mary Middle --- Last 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 526-32-0699		17. INFORMANT Kennett Lewis, (same)				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL EDEMA 1731 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Astrocytoma DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State 							
22a. I certify that (I) (the hospital) attended the deceased from 12 , 19 66 , to 12-31 , 19 67 , that (I) (was) last saw the deceased alive on 12-4 , 19 67 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did not) view the body after death.											
22b. SIGNATURE C. Earl Hill						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Jan. 2, 1967			
22d. PHYSICIAN'S NAME (Type) C. Earl Hill, M.D.						22e. ADDRESS 395 FT. SMALLWOOD RD. PASADENA, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 3, 1968		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.		23d. LOCATION (City or Town) (County) (State) Ritchie Hgwy., A.A.Co., Md.					
24. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hgwy., Baltimore						25a. REC'D BY REGISTRAR DATE JAN 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

16367				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				16359			
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 23 Acorn Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Joyce G. Loveless				4 DATE OF DEATH Month Dec Day 23 Year 1967							
5 SEX female		6 COLOR OR RACE cauc.		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 24 Sept. 1918		9. AGE (In years last birthday) 49 yrs.		10 IF UNDER 1 YEAR Months 4 Days 23 Hours 19 Min 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) secretary				10b KIND OF BUSINESS OR INDUSTRY wholesale auto parts				11. BIRTHPLACE (County & State, or foreign country) Maryland			
13. FATHER'S NAME Joseph Stubbins				14. MOTHER'S MAIDEN NAME Marian Summers				12 CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 579-18-5735		17. INFORMANT Walter E. Loveless - same as #2 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CPR failed DUE TO (b) OBSTRUCTION, SMALL BOWEL DUE TO (c) EXTENSIVE SCANTIOUS CELL CARCINOMA OF COLON CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DEHYDRATION WITH MARKED EXTENSION AND METASTASIS										INTERVAL BETWEEN ONSET AND DEATH 2 weeks 4 weeks 5 yrs and 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. DEHYDRATION										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) ---							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---			
21 I certify that (I) (this hospital) attended the deceased from MARCH, 1967 to DEC 23, 1967 , that (I) (we) last saw the deceased alive on DEC 22, 1967 , and that death occurred at 10:30 A.M. from causes and on the date stated above.											
22a. SIGNATURE Robert A. Riley, Jr.				22b. DATE SIGNED 12/23/67				22c. PHYSICIAN'S NAME (Type) ROBERT A. RILEY, JR.			
22d. ADDRESS 95 CATHEDRAL ST. ANNAPOLIS MD											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Dec. 27, 1967		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cem.		23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md.			
24. FUNERAL DIRECTOR Beverley E. Hopping				25a. REC'D BY REGISTRAR DEC 27 1967				25b. REGISTRAR'S SIGNATURE 2400 Judge			
HOPPING FUNERAL HOME - Annapolis, Md.											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16363

16363

1. PLACE OF DEATH a. COUNTY AA MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Laurel Convalescent Hm				d. STREET ADDRESS 511 Second Avenue SW		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas (nm) Mahon				4. DATE OF DEATH Month 12 Day 13 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/22/1877		9. AGE (In years last birthday) 90 yrs	IF UNDER 1 YEAR Months 12 Days 13 Hours 13 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) cab driver (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (County & State, or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Mahon				14. MOTHER'S MAIDEN NAME Mary Mahon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 079-28-9444A		17. INFORMANT Mrs. Helen Mahon Address Hospital char (wife) Same As #2			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial infarction DUE TO ASHD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary infection Diabetes Senility						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/11/67 , 19 to 12/13/67 , 19, that (I) (we) lost saw the deceased alive on 12/12/67 , 19, and that death occurred at 3:30 M, from causes and on the date stated above.							
22a. SIGNATURE J.B. Ramirez				22b. DATE SIGNED 12/13/67		22c. PHYSICIAN'S NAME (Type) J.B. RAMIREZ	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 16/1967		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City or town) (County) (State) Queens, New York, New York	
24. FUNERAL DIRECTOR R.V. Singleton				25a. REC'D BY REGISTRAR DEC 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16363

CERTIFICATE OF DEATH

16361

1 PLACE OF DEATH a COUNTY Anne Arundel		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c LENGTH OF STAY IN 1b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d STREET ADDRESS RFD, Box 263	
3. NAME OF DECEASED (Type or print) First Middle Last Don Richard Marshall		4. DATE OF DEATH Month Day Year December 17 1967	
5 SEX Male	6 COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7-30-10
9 AGE (In years last birthday) yrs. 57		10 UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b KIND OF BUSINESS OR INDUSTRY Maryland Transfer	
11 BIRTHPLACE (County & State, or foreign country) North Carolina		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Cleve Marshall		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO. 237-24-8682	
17 INFORMANT Mrs. Viola C. Marshall, same as 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/18 , 1967, to 11/18 , 1967, that (I) (we) last saw the deceased alive on 11/18 , 1967, and that death occurred at 11:40 AM , from causes and on the date stated above			
22a. SIGNATURE Edmond I. Moushabek		22b. DATE SIGNED 12/17/67	
22c. PHYSICIAN'S NAME (Type) Edmond I. Moushabek		22d. ADDRESS 510 Marley Station Rd, G.B.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 20 Dec. 67	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park	23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.
24 FUNERAL DIRECTOR Winkley Funeral Home, Glen Burnie, Md.		25a. RECD BY REGISTRAR DEC 20 1967	
		25b. REGISTRAR'S SIGNATURE James J. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 17 Film G346 1/3/68 kk
CERTIFICATE OF DEATH

16370

16362

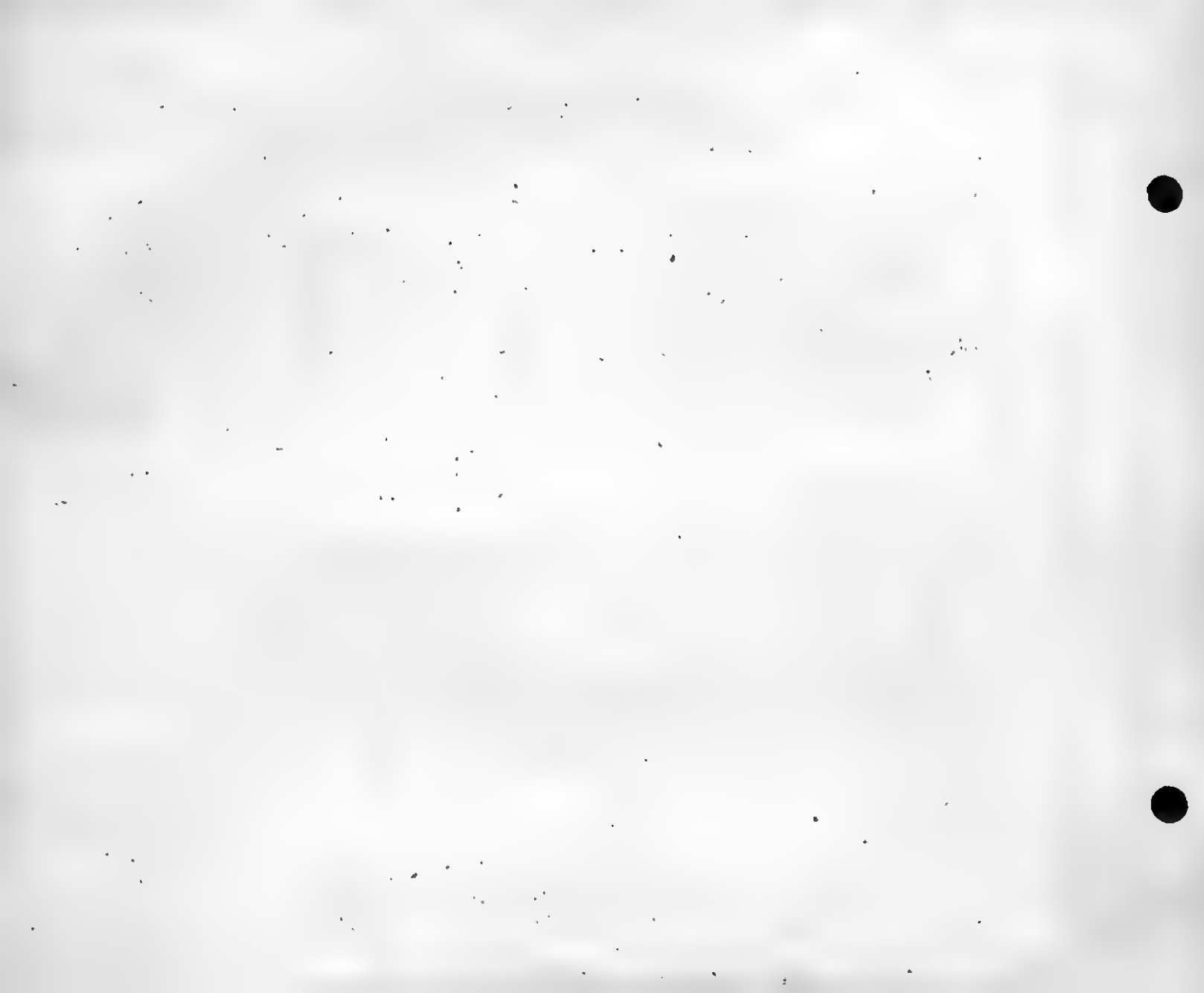
1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 168 Green Street	
3 NAME OF DECEASED (Type or print) Katie Bell MARSHALL		4. DATE OF DEATH Month December Day 24 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 18, 1890
9. AGE (in years lost birthday) 77 yrs		IF UNDER 1 YEAR Months 7 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (County & State or foreign country) Annapolis Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME EVERETT HUBBARD		14. MOTHER'S MAIDEN NAME MARGARET THOMPSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) —		16. SOCIAL SECURITY NO —	
17. INFORMANT MRS. Ralph THOMPSON		Hubbard Address #2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DEFERENTIAL EDEMA - DUE TO (b) CORONARY THROMBOSIS DUE TO (c) ARTEROSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 5 HOURS 2 DAYS 10 YEARS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART (a) DIABETES MELLITUS UREMIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JAN 2, 1961 to 24 DEC, 1967 , that (I) (we) last saw the deceased alive on 24 DEC 1967 , and that death occurred at 12:51 P. M. from causes and on the date stated above			
22a. SIGNATURE Edward S. Beck		22b. DATE SIGNED 12/26/67	
22c. PHYSICIAN'S NAME (Type) EDWARD S. BECK		22d. ADDRESS Franklin St. Annapolis, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12-28-67	23c. NAME OF CEMETERY OR CREMATORY ST. ANNE'S	23d. LOCATION (City or Town) (County) (State) Annapolis A.D. MD.
24. FUNERAL DIRECTOR John M. Taborius Annapolis, Md.		25a. REC'D BY REGISTRAR DEC 27 1967	
25b. REGISTRAR'S SIGNATURE J. J. Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16371										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16363																																							
1 DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
James H MASON										12 25 67										M																																							
3 SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN									
Male										Colored										1/27/1897										70 YRS																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
Maryland										U.S.A.																				Anne Arundel Md																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																													
Annapolis										U.S. General Hosp										Retired										Annapolis																													
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission to STATE)										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
1424 Hipson St										Anne Arundel Annapolis Md																				14401 Hipson St.																													
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
Mansfield										Mason										Emma Jackson																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown (If yes, give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
																				Marie Mason										Annapolis Md																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF (b)										DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
443X										Cerebral Pulmonary Embolism										Coronary Arteriosclerosis										One Month																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																														One Month																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from Dec 1, 1967, to Dec 25, 1967, that (I) (we) last saw the deceased alive on Dec 25, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										DEGREE										ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED																													
R. R. Richardson M.D.										M.D.																				12/27/67																													
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
R. R. Richardson M.D.										100-4444 St H N N A P A B I S																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										12/29/67										John Wesley										Staterburg A. A. Md.																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
William Lee										11-111111										DATE JAN 2 1968										in office																													

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16372

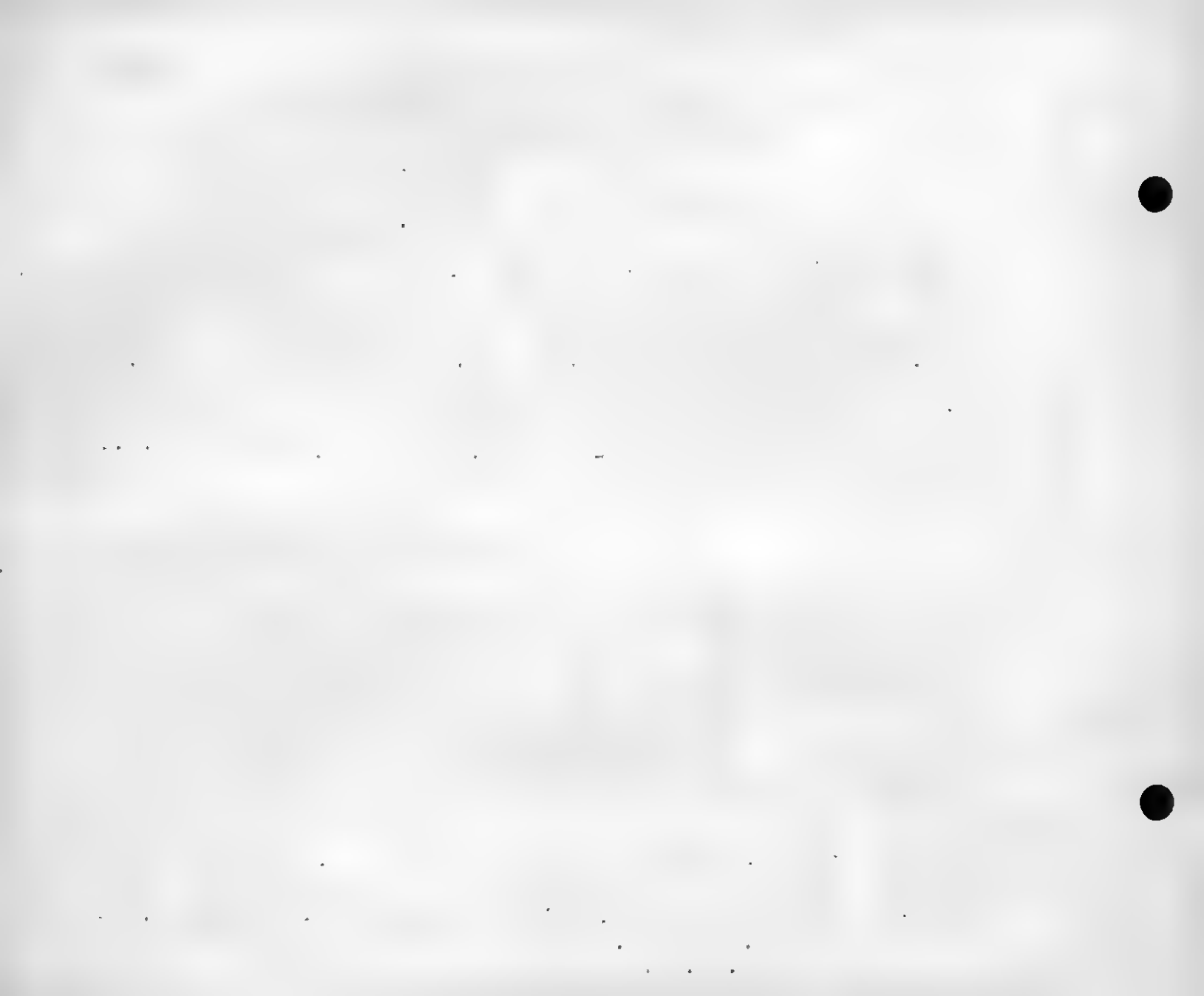
CERTIFICATE OF DEATH

16364

1 PLACE OF DEATH a COUNTY <u>ANNE ARUNDEL Cty.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mayo,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>P.O. Box 44 Mayo, Md.</u>		d. STREET ADDRESS <u>P. O. Box 44</u>	
3 NAME OF DECEASED (Type or print) <u>HARRY VERNON MAULDING</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>18</u> Year <u>1967</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-93</u>
9. AGE (in years last birthday) yrs <u>74</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov. Worker-Engineer of Dept. of Int.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VIRGINIA</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JAMES E MAULDING</u>		14. MOTHER'S MAIDEN NAME <u>THERESA C. FANNON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>212-36-0698</u>	
17. INFORMANT <u>Mrs. Theresa C. Warring</u>		Address <u>9600 Dilston S.S., Md. Br</u>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>(Probable) Cardiac arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery insufficiency</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>instantly</u> <u>10 yrs.</u> <u>15 yrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1965</u> to <u>Dec. 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 21</u> 19 <u>67</u> , and that death occurred at <u>home</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John L. Hedeman</u>		22b. DATE SIGNED <u>12/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John L. Hedeman</u>		22d. ADDRESS <u>Annapolis, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>12/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 26 1967</u>	
ADDRESS <u>2901 14th St. N. W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
16373			
16365			
1 PLACE OF DEATH a COUNTY ANNE ARUNDEL		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ANNE ARUNDEL	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G MEADE, MARYLAND		c LENGTH OF STAY IN 1b 17 Days	
d NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) KIMBROUGH ARMY HOSPITAL		d STREET ADDRESS 426 ARBOR DRIVE	
3 NAME OF DECEASED (Type or print) JOHN THOMAS MC COY		4 DATE OF DEATH Month DECEMBER Day 11 Year 19 67	
5 SEX MALE	6 COLOR OR RACE CAU	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/15/1929
9 AGE (In years last birthday) 38 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	11 IF UNDER 24 HRS Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET USA		10b KIND OF BUSINESS OR INDUSTRY SOLDIER	
11 BIRTHPLACE (County & State, or foreign country) WEBSTER, NY.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME WILLIAM HENRY MC COY		14 MOTHER'S MAIDEN NAME JANET E. BROWN	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES 1948-Apr 66		16 SOCIAL SECURITY NO. 081-32-8110	
17 INFORMANT BEVERLY MC COY(W) Same as # 2		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SHOCK, PULMONARY EDEMA, CONGESTIVE HEART FAILURE DUE TO FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Approx 1yr	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Month 11 Day 19 Year 1967 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 24 Nov 1967 to 11 Dec 1967, that (X) (we) last saw the deceased alive on 11 Dec 67 1967, and that death occurred at 3:30A, from causes and on the date stated above.			
22a SIGNATURE Lynn W. Holder, CPT, MC		22b DATE SIGNED 11 Dec 67	
22c PHYSICIAN'S NAME (Type) LYNN W. HOLDER, CPT, MC		22d ADDRESS KIMBROUGH ARMY HOSPITAL, FT GEO G MEADE MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 12/14/67	23c NAME OF CEMETERY OR CREMATORY Arlington National	23d LOCATION (City or Town) (County) (State) Arlington, Virginia
24 FUNERAL DIRECTOR Raymond C. Fink		25a REC'D BY REG STRAR Glen Burnie, Md. DATE DEC 14 1967	
25b REG STRAR'S SIGNATURE Charles Judge			

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>A-A</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A-A Co Gen Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A-A Co</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> d. STREET ADDRESS <u>27 Sunset Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>NETTIE Mae McCulloch</u>		4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-30-94</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if not read) <u>Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept Store</u>	9. AGE (In years last birthday) <u>73</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Charles Malpas</u>		14. MOTHER'S MAIDEN NAME <u>Louise Winkler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>38039927A</u>	
17. INFORMANT <u>Mrs Donald Cross - Above</u>		Address <u>Albany</u>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic glomerulonephritis</u> DUE TO (b) <u>57-X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-31-</u> , 19 <u>63</u> to <u>12/22</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>12/22</u> 19 <u>67</u> , and that death occurred at <u>1:35A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Richard T. Hochman</u> M.D.		22b. DATE SIGNED <u>12/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard T. Hochman, M.D.</u>		22d. ADDRESS <u>16 Murray Avenue, Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremated</u>	23b. DATE THEREOF <u>12-24-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lee Crematory</u>	23d. LOCATION (City or town) (County) (State) <u>Washington D C</u>
24. FUNERAL DIRECTOR <u>Robert S. Senawar, Severna Park, Md.</u>		25. REC'D BY REGISTRAR <u>DEC 26 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)
20 M 1/66

16375

CERTIFICATE OF DEATH

16367

1 PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville c. LENGTH OF STAY IN lb 1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Knollwood Manor Nursing Home		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie d. STREET ADDRESS Knollwood Manor Nursing Home e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Fannie B. McQuay		4 DATE OF DEATH Dec. 19 19 67	
5 SEX F	6 CO. OR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6/23 1879
9 AGE (In years last birthday) 88 yrs		10 IF UNDER 1 YEAR Months 19 Days 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY ----	
11 BIRTHPLACE (County & State, or foreign country) Talbot County, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William T. Morris		14 MOTHER'S MAIDEN NAME Anna Jester	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO ----	
17 INFORMANT Mrs. Maysie Cayer,		18 ADDRESS 414 Maple Ave., Glen Burnie, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) Congestive heart failure DUE TO (c) Atherosclerotic Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/7 , 19 66 , to 12/19 , 19 67 , that (I) (we) last saw the deceased alive on 12/12 , 19 67 , and that death occurred at AM , from causes and on the date stated above			
22a. SIGNATURE Ray M. Smith		22b. DATE SIGNED 12/19/67	
22c. PHYSICIAN'S NAME (Type) Ray M. Smith, M. D.		22d. ADDRESS Hahn Professional Bldg., Severna Pk., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF December 21, 1967	
23c. NAME OF CEMETERY OR CREMATORY Bozman Cemetery		23d. LOCATION (City or Town) (County) (State) Bozman, Maryland	
24. FUNERAL DIRECTOR Harison E. Leonard, St. Michaels Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE DEC 27 1967	



CERTIFICATE OF DEATH

13369

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - GLEN BURNIE		c. LENGTH OF STAY IN lb 22 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL HOSPITAL		d. STREET ADDRESS APT 1245 SCOTT MANOR	
3. NAME OF DECEASED (Type or print) HERSCHEL D MEEK		4. DATE OF DEATH Month DECEMBER Day 14 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 28, 1899
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ESTIMATOR		10b. KIND OF BUSINESS OR INDUSTRY LUMBER COMPANY	
11. BIRTHPLACE (County & State, or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gary D Meek		14. MOTHER'S MAIDEN NAME Cloddeah Shearer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 451-03-7982	
17. INFORMANT Marguerite Meek wife		Address same as the	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial 4201 DUE TO Infarction - Anterior septal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) C. Thrombosis (c) C. Thrombosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/22, 1967 to 12/14, 1967 , that (I) (we) last saw the deceased alive on 12/13, 1967 , and that death occurred at 12/14/67 , from causes and on the date stated above.			
22a. SIGNATURE Febus Grunberg, M.D.		22b. DATE SIGNED 12/15/67	
22c. PHYSICIAN'S NAME (Type) Febus Grunberg, M.D.		22d. ADDRESS 1115 Old Odenton Rd, Odenton	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Dec 18, 1967	23c. NAME OF CEMETERY OR CREMATORY I.O.F. Cemetery	23d. LOCATION (City or Town) (County) (State) Fredrick Town, Md.
24. FUNERAL DIRECTOR E.B. Fleming		25a. REC'D BY REGISTRAR Charles Jones	
25b. REGISTRAR'S SIGNATURE Charles Jones		DATE DEC 19 1967	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
25M 1/67

<div style="display: flex; justify-content: space-between;"> <div>1637</div> <div> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div> <div>16368</div> </div>											
1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Annapolis Nursing Home						d. STREET ADDRESS Rt 2 Box 220					
3 NAME OF DECEASED (Type or print) Margaret Meredith						4. DATE OF DEATH Month 12 Day 4 Year 1967					
5 SEX female		6 COLOR OR RACE cais.		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8 DATE OF BIRTH Mar. 30, 1879		9 AGE (In years lost birthday) yrs 88		IF UNDER 1 YEAR Months 4 Days 19 Hours 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired clerk				10b KIND OF BUSINESS OR INDUSTRY US Gov't		11. BIRTHPLACE (County & State, or foreign country) unknown				12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William M. Meredith						14. MOTHER'S MAIDEN NAME Terressa A. Richey					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. unknown		17 INFORMANT Mrs. Margaret Arrington - same as #2 above					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21 I certify that (I) (this hospital) attended the deceased from 6/3 , 19 67 to 12/4 , 19 67 , that (I) (we) last saw the deceased alive on 11/9 , 19 67 , and that death occurred at 12:45 PM , from causes and on the date stated above.											
22a. SIGNATURE Richard I. Hochman						22b DATE SIGNED 12/4/67		22c PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.			
22d ADDRESS 16 Murray Avenue, Annapolis, Md.											
23a BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial				23b DATE THEREOF 12/6/67		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION (City or Town) (County) (State) Suitland Prince George Md.			
24 FUNERAL DIRECTOR HOPPING FUNERAL HOME - Annapolis, Md.						25a REC'D BY REGISTRAR DEC 5 1967		25b REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
16378													
CERTIFICATE OF DEATH													
16370													
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital						d. STREET ADDRESS 21 Wilelinor Drive							
3. NAME OF DECEASED (Type or print) First Julia Middle Teresa Last MOGGACH						4. DATE OF DEATH Month December Day 8 Year 1967							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 12, 1881		9. AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR Months 8 Days 19 Hours 67			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME				10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (County & State, or foreign country) Ireland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME JAMES GARVEY						14. MOTHER'S MAIDEN NAME MARY GARVEY							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. —		17. INFORMANT GEORGE MOGGACH #2							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO (b) Wound from infection DUE TO (c) Cerebral thrombosis												INTERVAL BETWEEN ONSET AND DEATH Days Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 11/1 , 1964, to 12/8 , 1967, that (I) (we) last saw the deceased alive on 12/8 , 1967, and that death occurred at 11:40 P.M. from causes and on the date stated above.													
22a. SIGNATURE General Blue						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12/9/67					
22c. PHYSICIAN'S NAME (Type) General Blue						22d. ADDRESS 121 CATHEDRAL ST ANNAPOLIS MD							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF 12-11-67		23c. NAME OF CEMETERY OR CREMATORY ST. MARYS		23d. LOCATION (City or Town) (County) (State) ANNAPOIS A.A. MD.					
24. FUNERAL DIRECTOR John M. & Sons						ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR DEC 12 1967		25b. REGISTRAR'S SIGNATURE J. J. Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

<div style="display: flex; justify-content: space-between;"> <div> 16379 <div style="text-align: center;"> <div>Item 7 539 1/24 58 kk</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> </div> </div> </div> <div style="text-align: right;"> 16371 </div> </div>													
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE ALABAMA b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEO G MEADE, MD.				c. LENGTH OF STAY in 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PLEASANT GROVE							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL						d. STREET ADDRESS 233 14th STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last DON A MOODY						4. DATE OF DEATH Month Day Year DECEMBER 22 19 67							
5. SEX MALE		6. COLOR OR RACE CAU.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 18 SEP 23		9. AGE (In years lost birthday) 44 yrs.		10. F UNDER 1 YEAR Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired) SOLDIER				10b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY		11. BIRTHPLACE (County & State or foreign country) RUSSELLVILLE, ALABAMA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JAMES R. MOODY						14. MOTHER'S MAIDEN NAME NANCY B. (MAIDEN NAME UNKNOWN)							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of serv se) YES 8 NOV 54 / 22 DEC 67				16. SOCIAL SECURITY NO 4-16-68 6903		17. INFORMANT Address UNIT PERSONNEL RECORDS 42d GP, FT GEO G M, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE IN (R) PARIETAL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) AREA ORGANIZING DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)												19. WAS ALTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospo) attended the deceased from 21 DEC 1967 to 22 DEC 1967, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 22 DEC 1967, and that death occurred at 6:33 AM, from causes and on the date stated above.													
22a. SIGNATURE Richard P Behrendt						M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 22 DEC 67					
22c. PHYSICIAN'S NAME (Type) RICHARD P. BEHRENDT						22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-26-67		23c. NAME OF CEMETERY OR CREMATORY K of P CEMETERY				23d. LOCATION (City or Town) (County) (State) RUSSELLVILLE, ALA.					
24. FUNERAL DIRECTOR Ad. Co. F.H. of H.H. Witzke						ADDRESS Elliot City		25a. REC'D BY REGISTRAR DEC 26 1967		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATE

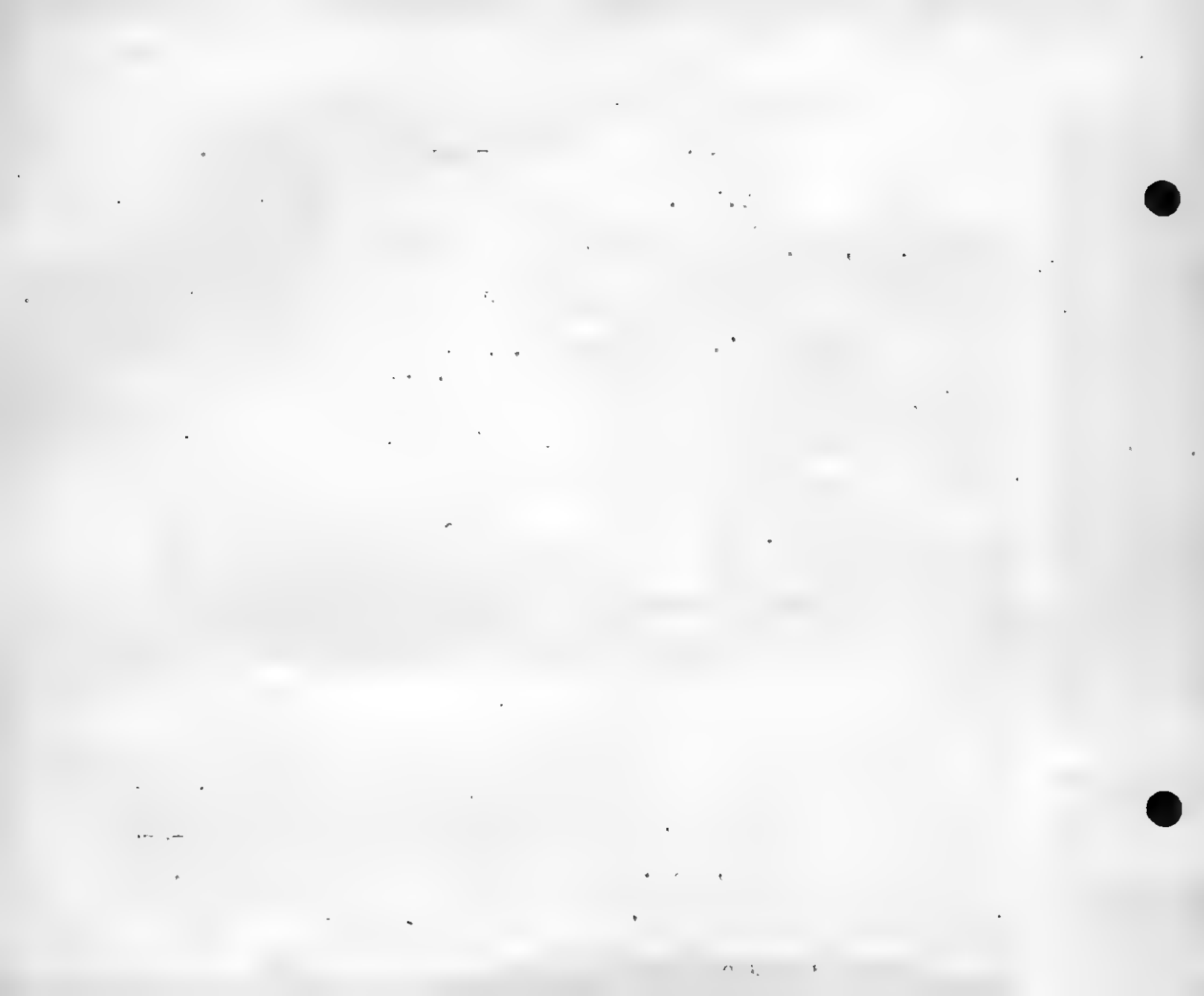
2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16380		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				16372	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print) Darwin Lindsay Moore			2a. DATE OF DEATH Month 12 Day 31 Year 67			2b. HOUR 10:50 AM	
3 SEX Male		4 RACE Negro		5 DATE OF BIRTH 8-22-67		6 AGE (in years last birthday) 4 mos.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel County Md.	
10. CITY OR TOWN OF DEATH Pasadena, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. CITY OR TOWN Anne Arundel		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER Box 498, Magothy Beh.	
14 FATHER'S NAME Donald L. Moore		15. MOTHER'S MAIDEN NAME Barbara Mae Lee					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16b. SOCIAL SECURITY NO. N/A		17 INFORMANT Patients Chart			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status Thymicolymphe DUE TO, OR AS A CONSEQUENCE OF fever Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF ? Virus Pneumonia (c) ?						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Dec 29, 1967 , to Dec 31, 1967 , that (I) (we) last saw the deceased alive on Dec 31, 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death TIME 10:20 AM of 12/31/67							
22b. SIGNATURE Max Frank				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-1-68	
22d. PHYSICIAN'S NAME (Type) Max Frank, M.D.				22e. ADDRESS Arundel Medical Group, Glen			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1/4/68		23c. NAME OF CEMETERY OR CREMATORY MT ZION Ch. Cem.		23d. LOCATION (City or Town) (County) (State) Magothy Md.	
24 FUNERAL DIRECTOR Morton and Dyett Funeral Home				25a. REC'D BY REGISTRAR JAN 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16381

16373

1. PLACE OF DEATH a. COUNTY <u>ALVE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALVE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>167 GREEN ST.</u>		d. STREET ADDRESS <u>167 GREEN ST</u>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>M. Mynroe</u> Middle <u>Lost</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 24, 1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY RET. INSURANCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ANNAPOLIS MD</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>CHARLES GRAFTON Mynroe</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE GIRAULT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>ELIZABETH C. Mynroe #2</u>		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4550 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Centriocerebotic cardiovascular disease</u> (c) <u>6 yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'o m. 19 p m	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>60</u> , to <u>Dec</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/9</u> 19 <u>67</u> , and that death occurred at <u>2 A.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>John H. Hederman</u>		22b. DATES SIGNED <u>12/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN HEDERMAN</u>		22d. ADDRESS <u>FOREST DR ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>DEC 15 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. HUNES</u>	23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS A.H. MD.</u>
24. FUNERAL DIRECTOR <u>John M. [unclear] Annapolis, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 18 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[unclear]</u>	



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VR A13-1
30M REV. 7-64

16382										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16374																													
1 DECEASED-NAME (Type or print)										2a DATE OF DEATH										2b HOUR																													
First Middle Last ROY S. NEARY										Month Day Year December 31, 1967										1100 PM																													
3. SEX MALE										4 RACE WHITE										5. DATE OF BIRTH MARCH 5, 1910										6 AGE (In years last birthday) 57 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN									
7a BIRTHPLACE (State or foreign country) Severn, Md.										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. COUNTY OF DEATH ANNE ARUNDEL CO. Md.																			
10. CITY OR TOWN OF DEATH MILLERSVILLE,										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) KNOLLWOOD NURSING HOME										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired										12b KIND OF BUSINESS OR INDUSTRY Civil Service																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. COUNTY Anne Arundel										13c CITY OR TOWN Gambrills										13d INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e STREET AND NUMBER Box #156									
14 FATHER'S NAME First Middle Last HARRY NEARY										15 MOTHER'S MAIDEN NAME First Middle Last LAURA WHITEHEAD																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO										16b SOCIAL SECURITY NO 717 07 6672										17 INFORMANT Mrs. Helen L. Stach (daughter)										Address Same As 13c																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis, general & coronary</u> Candidans, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus</u>																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																													
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from <u>29 Dec, 1967</u> to <u>31 Dec, 1967</u> , that (I) (we) last saw the deceased alive on <u>29 Dec, 1967</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE <u>Charles W. Kinzer</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c DATE SIGNED 2 Jan 1968																													
22d. PHYSICIAN'S NAME (Type) Charles W. Kinzer										22e. ADDRESS Annapolis, Maryland																																							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b DATE JAN. 3, 1968										23c. NAME OF CEMETERY OR CREMATORY Trinity Meth. Ch. Cem.										23d. LOCATION (City or Town) (County) (State) Odenton, A.A. Co., Md.																			
24. FUNERAL DIRECTOR <u>R. L. Singleton</u>										SINGLETON FUNERAL HOME GLEN BURNIE, MD.										25a. REC'D BY REGISTRAR DATE JAN 3 1968										25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16383

16375

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Shady Side	
3. NAME OF DECEASED (Type or print) Jerome NICK		4. DATE OF DEATH Month December Day 20 Year 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1887
9. AGE (In years last birthday) yrs. 80		10. UNDER 24 HRS. Months 20 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William T. Nick		14. MOTHER'S MAIDEN NAME Hattie Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Leonard Nick Shadyside		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia + uremia DUE TO (b) Arteriosclerotic nephrosclerosis DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) physician attended the deceased from Jan , 19 66 , to Dec. 20 , 19 67 that (I) had last saw the deceased alive on Dec. 20 , 19 67 , and that death occurred at 12:25 AM , from causes and on the date stated above.			
22a. SIGNATURE Willard F. Smith		22b. DATE SIGNED 12/20/67	
22c. PHYSICIAN'S NAME (Type) Willard F. Smith, MD.		22d. ADDRESS Shady Side, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-23-67	23c. NAME OF CEMETERY St. Matthews	23d. LOCATION (City or Town) (County) (State) Shadyside Md.
24. FUNERAL DIRECTOR William Reese # Anne Mc		25a. REC'D BY REGISTRAR DATE DEC 27 1967	
25b. REGISTRAR'S SIGNATURE W. J. Page			



TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, they will be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16384
CERTIFICATE OF DEATH
15376

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena c. LENGTH OF STAY in lb 18 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 256 Carroll Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena d. STREET ADDRESS 256 Carroll Rd.	
3. NAME OF DECEASED (Type or Print) HERMAN		4. DATE OF DEATH NORWOOD Sr. Month 12 Day 1 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1887
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 3 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Steel Co.	
11. BIRTHPLACE (County & State, or foreign country) Mt. Airy, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John E. Norwood		14. MOTHER'S MAIDEN NAME Clementine Gatrell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 212-07-55454	
17. INFORMANT Herman Norwood, Jr.		Address Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ACUTE CARDIO-RESPIRATORY FAILURE DUE TO (b) HEPATOMA (PRIMARY CANCER LIVER) DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH SUDDEN 3 MONTHS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from JUNE 19, 1961 to DEC. 1, 1967 , that (I) (we) last saw the deceased alive on 11-1-1967 , and that death occurred at 9 AM , from the causes and on the date stated above.			
22a. SIGNATURE Arthur Lankford Jr. MD		22b. DATE SIGNED 12-1-67	
22c. PHYSICIAN'S NAME (Type) ARTHUR LANKFORD, JR., M.D.		22d. ADDRESS PASADENA, MD 21122	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-4-1967	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town or county) (State) Pikesville, Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce-4001 Ritchie Hwy., Baltimore		25a. REC'D BY REGISTRAR DEC 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

16385

CERTIFICATE OF DEATH

16377

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>1 hr 45 min</u>		d. STREET ADDRESS <u>3133 Dillon St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edith A Novak</u>		4. DATE OF DEATH Month Day Year <u>Dec. 3 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-30-00</u>
9. AGE (In years last birthday) yrs. <u>67</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>ASAD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHF</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>12/3/67</u> , 19 <u>67</u> , to <u>12/3/67</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>12/3/67</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.	
22a. SIGNATURE <u>J. B. Ramirez</u>		22b. DATE SIGNED <u>12/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. B. RAMIREZ</u>		22d. ADDRESS <u>3521 ANNAPOLIS RD BALD 27 Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-7-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Beverly</u>		23d. LOCATION (City or Town) (County) (State) <u>Md.</u>	
24. FUNERAL DIRECTOR <u>Shelma D. Hoffmann</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

16386

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16378

1. PLACE OF DEATH a COUNTY ANNE ARUNDEL b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE c LENGTH OF STAY IN TB 21218 d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL CONVALESCENT CENTER		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY BALTIMORE c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d STREET ADDRESS 3805 Ad York Rd e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY O'BRIEN		4 DATE OF DEATH Month 12 Day 12 Year 67	
5. SEX FEM	6. COLOR OR RACE WH	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-24-1888
9 AGE (In years lost birthday) yrs 79		10 IF UNDER 1 YEAR Months 12 Days 12 Hours 67 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TIMEKEEPER BALTO-TRANSIT CO.		10b. KIND OF BUSINESS OR INDUSTRY WILMINGTON, DELA.	
11. BIRTHPLACE (County & State or foreign country) U.S.A.		12 CIT ZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES TAYLOR		14. MOTHER'S MAIDEN NAME SARAH BOWER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 213-10-9832	
17 INFORMANT MRS. AGNES CURRENS		Address (SAME)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Ventricular failure DUE TO Cerebro vascular accident (b) Generalized arteriosclerosis DUE TO Generalized arteriosclerosis (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH hours months years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary heart failure		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> hot While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/30, 1967 to 12/12, 1967 that (I) (we) last saw the deceased alive on 12/12 19 67 , and that death occurred at 6:15 AM , from causes and on the date stated above.			
22a. SIGNATURE Max C Frank		22b DATE SIGNED 12/12/67	
22c. PHYSICIAN'S NAME (Type) MAX C FRANK MD		22d ADDRESS 425 SE Ritchie Hwy	
23a BURIAL, CREMAT OR, REMOVAL (Specify) Burial		23b DATE THEREOF 12/15/67	
23c NAME OF CEMETERY OR CREMATORY New Cathedral		23d LOCAT ON (City or Town) (County) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a REC'D BY REGISTRAR DEC 13 1967	
ADDRESS 4905 York Road Baltimore, Md. 21212		25b. REGISTRAR'S SIGNATURE Charles Jones	

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16387

1. PLACE OF DEATH a. COUNTY <u>ANNAPURNDAL</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> c. LENGTH OF STAY IN 1b <u>LAUREL</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>LAUREL CHILDREN'S CENTER</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEORGE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LAUREL Hillcrest Heights</u> d. STREET ADDRESS <u>2822 CURTIS DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>GORDON</u> Last <u>OHUS</u>		4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1967</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-30-58</u>		9. AGE (in years last birthday) <u>9</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>				11. BIRTHPLACE (County & State, or foreign country) <u>NORTH DAKOTA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>GORDON OHUS</u>				14. MOTHER'S MAIDEN NAME <u>LEONA ?</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year and dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>MEDICAL CHART</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ASPIRATION</u> DUE TO (c) <u> </u>																INTERVAL BETWEEN ONSET AND DEATH <u>2 Mo 8 d</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MENTAL RETARDATION, CONVULSIVE DISORDER, SPASTIC QUADRIPLEGIA</u>																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from... 10 - 22, 1967, to 12 - 30, 1967, that (I) (we) last saw the deceased alive on... 12 - 30 1967, and that death occurred at... 10:35 P.M., from the causes and on the date stated above.																			
22a. SIGNATURE <u>Loretta K. Gilmore M.D.</u>								ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <u>12-31-67</u>							
22c. PHYSICIAN'S NAME (Type) <u>LORETTA K. GILMORE</u>								22d. ADDRESS <u>LAUREL CHILDREN'S CENTER, LAUREL, MD.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 1-5-68</u>				23b. DATE THEREOF <u>1-5-68</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Grafton Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Grafton N. Dakota</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. W. H. Danaher Laurel Md.</u>								25a. REC'D BY REGISTRAR <u>JAN 12 1968</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

16388

CERTIFICATE OF DEATH

16380

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital				a. STREET ADDRESS 305 Viewing Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Katie XXXXXXXX E. Parker				4. DATE OF DEATH December 15 1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-12-82	9. AGE (In years last birthday) 85 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US A	
13. FATHER'S NAME John K. Brown				14. MOTHER'S MAIDEN NAME Annie Hundley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Lillian M. Przylepa, 305 Viewing Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thromb DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Generalized Cerebral DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 weeks 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from December 10, 1967 , to December 15, 1967 , that (I) (we) last saw the deceased alive on December 15, 1967 , and that death occurred at 10:20 P.M. from causes on and on the date stated above.							
22a. SIGNATURE E. Roderick Shipley				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec 16, 1967	
22c. PHYSICIAN'S NAME (Type) E. Roderick Shipley				22d. ADDRESS 529 Camp Meade Road Linthicum, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-19-1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore County, Maryland	
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229				25a. REC'D BY REGISTRAR DATE DEC 22 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16381

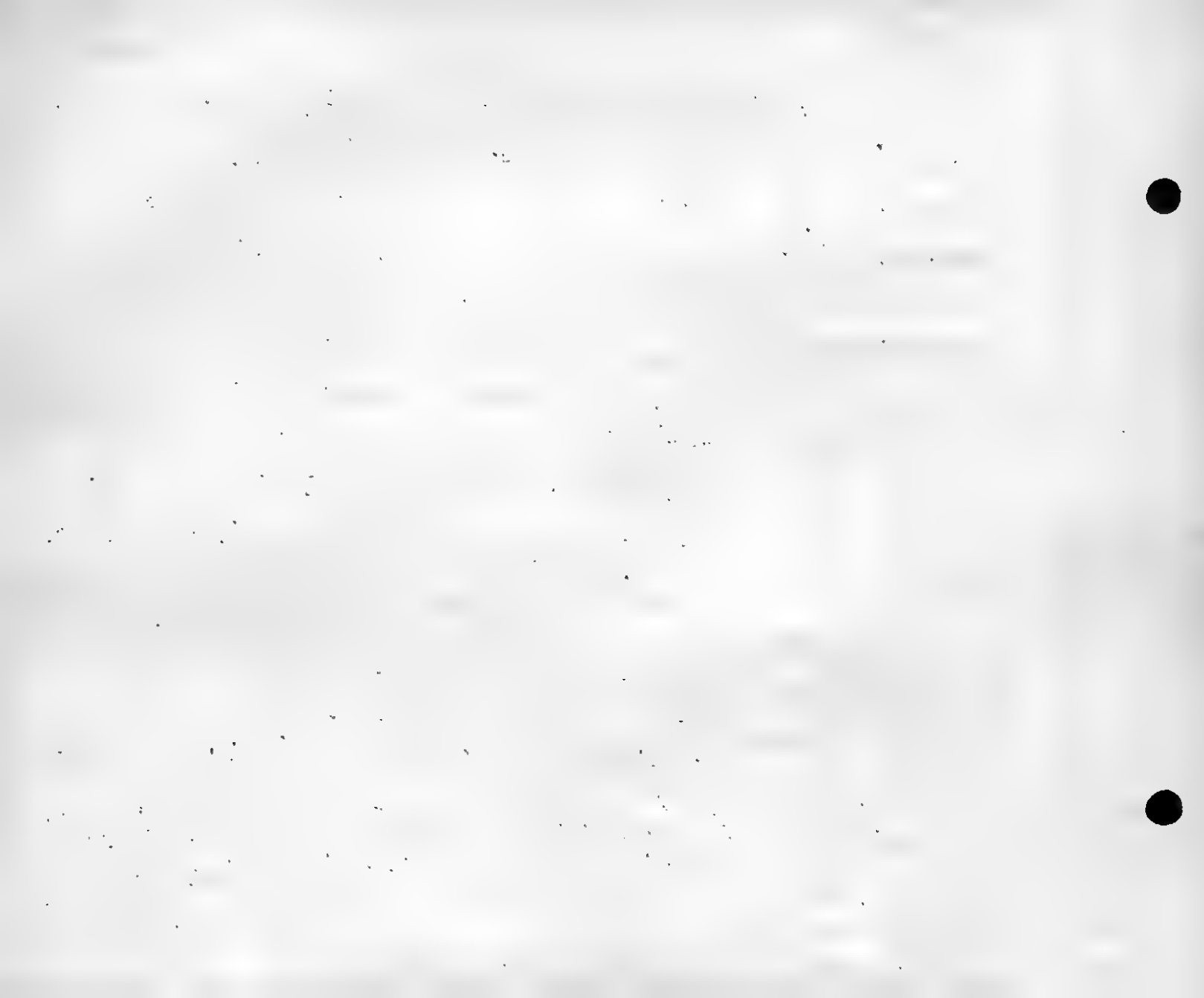
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16381

1. DECEASED NAME (Type or print) ELLA CATHERINE PARKS			2a. DATE OF DEATH Dec Month 22 Day 1967 Year			2b. HOUR 7:34 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept 19 1879		6. AGE (in years last birthday) 88 YRS.		7. UNDER YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Churchtown MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore MD			
10. CITY OR TOWN OF DEATH Churchtown MD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Lothian MD		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY AA		13c. CITY OR TOWN DEALE MD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last HEZERIAH FISHER			15. MOTHER'S MAIDEN NAME First Middle Last Sara Elizabeth Rogers Ward						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Alvin Parks Deale MD		Address			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) NONE								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks years	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12/18/67 , 19__ to 12/21/67 , 19__, that (I) (we) last saw the deceased alive on 12/21/67 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Charles H. Wirth MD				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/23/67	
22d. PHYSICIAN'S NAME (Type) Charles H. Wirth MD				22e. ADDRESS Lothian Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-24-67		23c. NAME OF CEMETERY OR CREMATORY St James		23d. LOCATION (City or Town) (County) (State) Tracy's AA MD			
24. FUNERAL DIRECTOR Bertrand Harold Haskins				ADDRESS Stokesville Md		25a. REC'D BY REGISTRAR DEC 29 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

16390				16382			
1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut-on: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c LENGTH OF STAY IN lb <u>81 yr</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Galesville</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Edith Glover PEAKE</u>			4. DATE OF DEATH Month Day Year <u>December 11 19 67</u>				
5 SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>October 15, 1886</u>	
9 AGE (In years last birthday) yrs. <u>81</u>		IF UNDER 1 YEAR Months Days <u>11 19 67</u>		IF UNDER 24 HRS Hours Min <u>11 19 67</u>			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Galesville Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>William Glover</u>		14. MOTHER'S MAIDEN NAME <u>Sally Parrish</u>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u>312 28 336-2</u>		17 INFORMANT <u>Raymond Peake Galesville Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <u>463 X</u> IMMEDIATE CAUSE (a) <u>Multiple Pulmonary Emboli</u> DUE TO (b) <u>Probable Thrombosis Lt Leg</u> DUE TO (c) <u>EX LT Hip</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>EX Femoral Neck LEFT</u>				19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FELL in YARD AT HOME</u>					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>11-28 19 67</u>		20d INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u>		20f (City or town) (County) (State) <u>Galesville MD MD</u>	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>Dec 11</u> , 19 <u>67</u> , and that death occurred at _____ M, from causes and on the date stated above.							
22a SIGNATURE <u>Bernard O. Hardesty</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>10:15 P.M.</u>	
22c PHYSICIAN'S NAME (Type) <u>Bernard O. Hardesty</u>				22d ADDRESS <u>Galesville Md.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>12-14-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Woodfield</u>		23d LOCATION (City or town) (County) (State) <u>Galesville MD MD</u>	
24 FUNERAL DIRECTOR <u>Bernard O. Hardesty</u>				ADDRESS <u>Galesville Md.</u>		25a REC'D BY REGISTRAR <u>DEC 18 1967</u>	
				25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1639 10383										
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Orchard Beach				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Orchard Beach				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7812 Waterview Drive 21226					d. STREET ADDRESS 7812 Waterview Drive 21226			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Frederick Henry Pepersack					4. DATE OF DEATH Month Day Year December 15, 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 29, 1898		9. AGE (in years last birthday) 69 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist			10b. KIND OF BUSINESS OR INDUSTRY Int. Bedding Co.			11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Frederick Wm. Pepersack					14. MOTHER'S MAIDEN NAME Lena Meyer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mrs. Margaret Gunther 7825 Bridge Dr. 21226			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis 1500 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none								INTERVAL BETWEEN ONSET AND DEATH 2 years		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Mar. 1, 1954 to December 15, 1967 , that (I) (we) last saw the deceased alive on December 16, 1967 , and that death occurred at 2 A M, from the causes and on the date stated above.										
22a. SIGNATURE R. M. McLaughlin					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/15/67			
22c. PHYSICIAN'S NAME (Type) R. M. McLaughlin					22d. ADDRESS 3708 Mountain Rd. Pasadena, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/18/67		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park		23d. LOCATION (City, town or county) (State) Howard Co. Md.			
24. FUNERAL DIRECTOR McCully F. H.					ADDRESS 237 Patapsco Ave. 21225		25a. REC'D BY REGISTRAR DEC 18 1967		25b. REGISTRAR'S SIGNATURE William J. Jones	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16392

CERTIFICATE OF DEATH

17887

1. PLACE OF DEATH a. COUNTY <u>17 17</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEALE</u>		c. LENGTH OF STAY IN lb <u>15 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Moody Phipps</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/1902</u>
9. AGE (In years lost birthday) yrs. <u>64</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Water mill</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea food</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>St. Michaels, Deale, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>163X</u> IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>Carcinoma of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>6 months</u> (c) <u>6 months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> , to <u>Dec 20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 19</u> , 19 <u>67</u> and that death occurred at <u>4:4</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Willard F. Smith</u>		22b. DATE SIGNED <u>12/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith MD</u>		22d. ADDRESS <u>Shady Side, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodfield</u>	23d. LOCATION (City or Town) (County) (State) <u>Edison, Md</u>
24. FUNERAL DIRECTOR <u>Benjamin</u>		25a. REC'D BY REGISTRAR <u>JAN 18 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Phonetic Jones</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16393

16384

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bay Manor Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> d. STREET ADDRESS <u>Rt. #2, Box #214 Belhaven Beach</u>			
3 NAME OF DECEASED (Type or print) <u>HERMAN U. PLATZKE</u> First Middle Last 4 DATE OF DEATH <u>DECEMBER 28, 1967</u> Month Day Year				5 SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 14, 1880</u> 9. AGE (In years last birthday) <u>87</u> yrs. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Dansi, Germany</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>(unknown) Platzke</u> 14. MOTHER'S MAIDEN NAME <u>(unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>212 07 1783</u> 17. INFORMANT <u>Charles R. Platzke (son) Same as #2</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia Right lower lobe</u> 4110 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic cardiovascular disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>Dec 27, 1967</u>, and that death occurred at _____ M, from causes on and on the date stated above. 22a. SIGNATURE <u>Ray M. Smith</u> 22c. PHYSICIAN'S NAME (Type) <u>Ray M. Smith</u> 22b. DATE SIGNED <u>Dec 30, 1967</u> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22d. ADDRESS <u>Severna Park, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Dec. 30/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u> 23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Maryland</u>							
24. FUNERAL DIRECTOR <u>Singleton Funeral Home</u> ADDRESS <u>Glen Burnie, Md</u> 25a. REC'D BY REGISTRAR <u>JAN 4 1968</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

MEDICAL CERTIFICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital						2 USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 71 Conduit Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) Alexander Hamilton POLK First Middle Last						4 DATE OF DEATH December 26 19 67 Month Day Year					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 20, 1889 lost birthday) 78 yrs.		9. AGE (In years)		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. ENGINEER				10b. KIND OF BUSINESS OR INDUSTRY DEPT OF US ARMY		11. BIRTHPLACE (County & State, or foreign country) ASHVILLE, N.C. VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME FRANCIS DZVERUX POLK						14. MOTHER'S MAIDEN NAME MARGARET CALLAWAY					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO		17. INFORMANT MARGARET E. POLK #2 Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 161A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary of Myocard (c) INTERVAL BETWEEN ONSET AND DEATH Days Months										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12/1 , 19 67 , to 12/26 , 19 67 , that (I) (we) last saw the deceased alive on 12/26 , 19 67 , and that death occurred at 7:15 P.M. M. from causes and on the date stated above.											
22a. SIGNATURE General Church						M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12/27/67			
22c. PHYSICIAN'S NAME (Type) General Church						22d. ADDRESS 121 Cathedral St., Annapolis					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/29/67		23c. NAME OF CEMETERY OR CREMATORY LOUPON PARK CEM.		23d. LOCATION (City or Town) (County) (State) BALTIMORE MD					
24. FUNERAL DIRECTOR JOHN M. TAYLOR - SONS ANNAPOLIS MD						25a. REC'D BY REGISTRAR DATE DEC 29 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

16395

CERTIFICATE OF DEATH

16386

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c LENGTH OF STAY IN 1b 4 Days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e STREET ADDRESS 133 Round Bay Road	
3 NAME OF DECEASED (Type or print) Miriam Toombs RAKER		4 DATE OF DEATH December 16, 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH February 20, 1916
9 AGE (in years last birthday) 51 yrs		10 IF UNDER 1 YEAR Months 16 Days 19 Hours 67 Min.	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Conv. writer		10b KIND OF BUSINESS OR INDUSTRY Dent. Store	
11 BIRTHPLACE (County & State, or foreign country) Illinois		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME Claude H Toombs		14 MOTHER'S MAIDEN NAME Cleo Alhin	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO - - -	
17 INFORMANT Fredrick Baker		Address - Above	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5011 IMMEDIATE CAUSE (a) Liver Failure acute & chronic DUE TO (b) Laennec's Cirrhosis DUE TO (c) 3 weeks			INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on December 16 1967 , and that death occurred at 9:50 a.m. M, from causes and on the date stated above			
22a SIGNATURE Ray M. Smith		22b DATE SIGNED Dec.	
22c PHYSICIAN'S NAME (Type) RAY M. SMITH		22d ADDRESS Severna Park, Md	
23a BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b DATE THEREOF 12-16-67	23c NAME OF CEMETERY OR CREMATORY LEE CREMATORY	23d LOCATION (City or Town) (County) (State) WASHINGTON D.C.
24 FUNERAL DIRECTOR ROBERT S. BARRAWICK, PARK, MD		25a REC'D BY REGISTRAR DEC 20 1967	
		25b REGISTRAR'S SIGNATURE John J. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and return them to the funeral director. The funeral director should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16396

CERTIFICATE OF DEATH

16387

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY in 5 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 102 Woods Avenue	
3. NAME OF DECEASED (Type or print) First William Middle Henry Last REDELIUS		4. DATE OF DEATH Month December Day 28 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1904
9. AGE (in years last birthday) 63 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY General Motors	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Frederick Redelius		14. MOTHER'S MAIDEN NAME Hermie Higdon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-0392	
17. INFORMANT Mary N. Redelius, same as 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 3300 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ✓			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour : m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/24 , 1967, to 12/27 , 1967, that (I) (we) last saw the deceased alive on December 28, 1967 , and that death occurred at 2:10 M, from causes and on the date stated above.			
22a. SIGNATURE Gerard Rhural		22b. DATE SIGNED 12/29/67	
22c. PHYSICIAN'S NAME (Type) Gerard Rhural		22d. ADDRESS 121 Cathedral St. Annapolis Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1 Jan. 68	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial	23d. LOCATION (City or Town) (County) (State) Elkridge, Howard, Md.
24. FUNERAL DIRECTOR Winkley Funeral Home, Glen Burnie, Md. 21061		25a. REC'D BY REGISTRAR JAN 2 1968	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1639

16388

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. LENGTH OF STAY IN It <u>10-WEEKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake Md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Knollwood Manor</u>				d. STREET ADDRESS <u>186 Carroll St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Annie Louise Reid</u>				4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 11 1891</u>	9. AGE (In years last birthday) <u>76</u> yrs	F UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WM THOMAS PUGH</u>				14. MOTHER'S MAIDEN NAME <u>WAUGH</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>227-01-7804</u>		17. INFORMANT Address <u>AS ABOVE</u> <u>MABLE SWINDELL</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.V.A. & Rt hemiplegia</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>A.C.V.D.</u> DUE TO <u> </u> (c) <u>Sen aryl</u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1967</u> , 19 <u> </u> , to <u>1967</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>12-16-67</u> , and that death occurred at <u>5P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Robert B. Hahn</u>				M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>12-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert B. HAHN</u>				22d. ADDRESS <u>Severna Park Md</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Richmond, Virginia</u>			
24. FUNERAL DIRECTOR <u>Raymond C. Fink</u>				ADDRESS <u>Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 19 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1042. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/67

16393

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16389

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt. 2, Box 606A	
3. NAME OF DECEASED (Type or print) First Middle Last CLEMENTINE E. REIER		4 DATE OF DEATH Month Day Year December 9, 19 67	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/9/1930
9 AGE (In years last birthday) 37 yrs		10 UNDER 24 HRS Months Days Hours Min	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b KIND OF BUSINESS OR INDUSTRY -	
12 BIRTHPLACE (State or foreign country) Mass.		13 CITIZEN OF WHAT COUNTRY? U.S.A.	
14 FATHER'S NAME Walter Galenski		15 MOTHER'S MAIDEN NAME Anna Zalesuski	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		17 SOCIAL SECURITY NO 030-22-6049	
18 INFORMANT Edward W. Reier (above address)		Address	
19 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. 5 x 1.0 IMMEDIATE CAUSE (a) Fatty Alteration of Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) Partial		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22 DATE SIGNED 12/10/67			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 12/13/67	
23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d LOCATION (City or Town) (County) (State) Odessa Manor, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier Maryland	
25a REC'D BY REGISTRAR DEC 18 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16390

16390

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West River</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Residence West River (Rural)</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural West River</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ETHEL</u> <u>MARIE</u> <u>RENEHAN</u>		4. DATE OF DEATH Month Day Year <u>Dec.</u> <u>27</u> <u>19</u> <u>67</u>	
5. SEX <u>female</u> 6. COLOR OR RACE <u>Caus.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29, 1897</u> 9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>telephone operator</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>public utilities</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Bernard Norris</u> 14. MOTHER'S MAIDEN NAME <u>Lelia Hayden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>577 011 617</u> 17. INFORMANT <u>James J. Renehan - same as #2 above</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u> - <u>Influenza</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> <u>1967</u> to <u>Dec 27, 1967</u> that (I) (we) last saw the deceased alive on <u>Dec 26, 1967</u> and that death occurred at <u>4 AM</u> from the causes and on the date stated above 22a. SIGNATURE <u>Willard F. Smith</u> 22b. DATE SIGNED <u>12/28/67</u> 22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith, MD</u> 22d. ADDRESS <u>Shady Side, Md.</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Dec. 30, 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of Sorrows</u> 23d. LOCATION (City, town or county) <u>Owensville</u> <u>A.A.</u> <u>Md.</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Beverley E. Hopping</u> 25a. REC'D BY REGISTRAR <u>JAN 2 1968</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

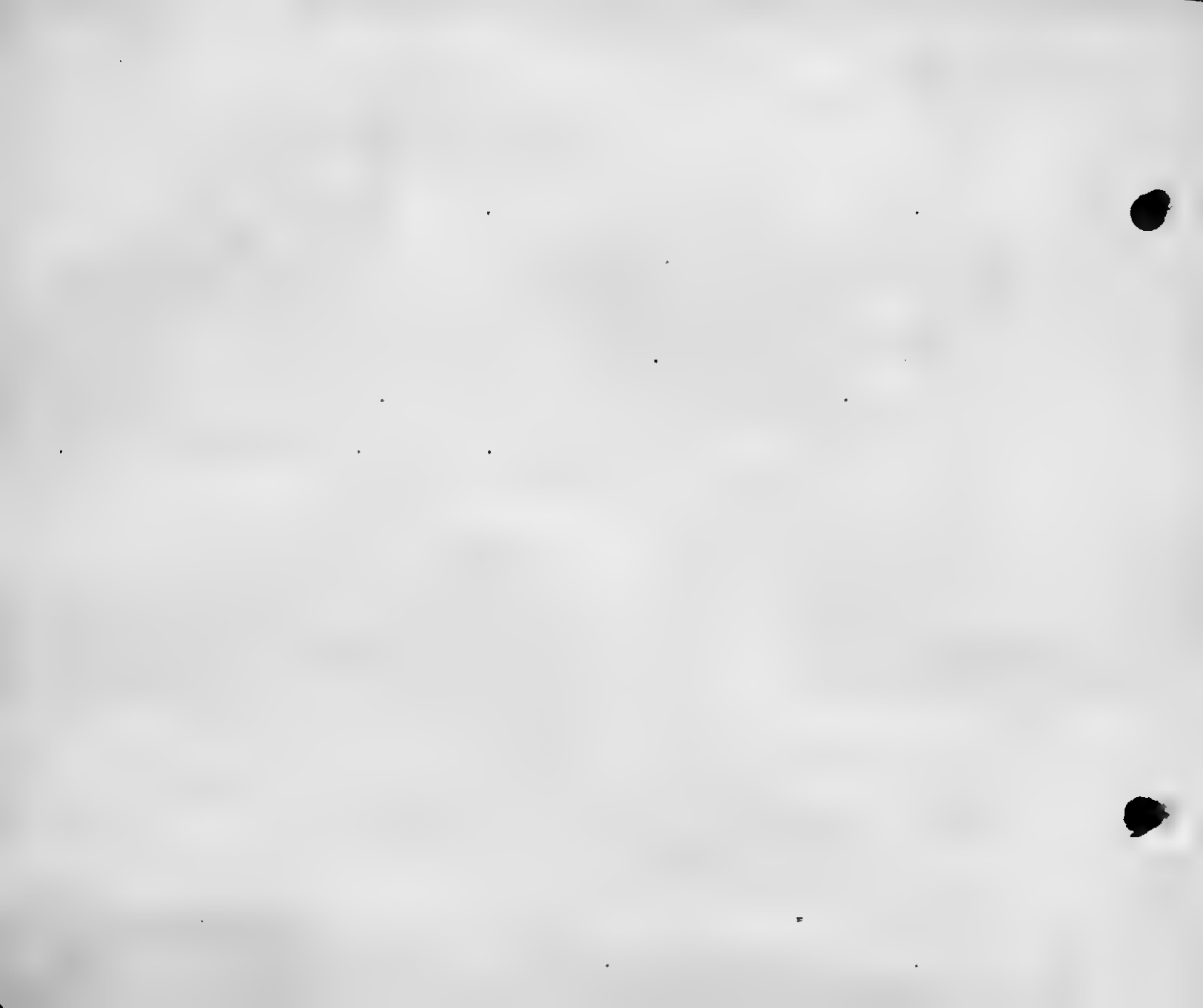
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 is to be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16400
16391
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) PASADENA c. LENGTH OF STAY IN 1b PASADENA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RT. 2 BOX 419		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) PASADENA d. STREET ADDRESS RT. 2 BOX 419 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES V. ROCK		4. DATE OF DEATH DEC 30 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-94
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER, RETIRED		10b. KIND OF BUSINESS OR INDUSTRY BALTO. CITY	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
13. FATHER'S NAME CHARLES V. ROCK		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WW I		16. SOCIAL SECURITY NO. 214405569 J2	
17. INFORMANT ELLA A. ROCK, Rt. 2 Box 419, Pasadena, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS DUE TO CARCINOMA PROSTATE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 6 MO. 4 YRS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JULY 30, 1963 to DEC 30, 1967 , that (I) (we) last saw the deceased alive on DEC 29, 1967 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Arthur Lankford Jr. MD		22b. DATE SIGNED 12-30-67	
22c. PHYSICIAN'S NAME (Type) ARTHUR LANKFORD JR. MD		22d. ADDRESS 2934 MOUNTAIN RD PASADENA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1-1-68	23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY	23d. LOCATION (City, town or county) (State) BALTIMORE, MD.
24. FUNERAL DIRECTOR'S SIGNATURE HOWARD H. HUBBARD 4107 WILKENS AVE. 21229		25a. REC'D BY REGISTRAR JAN 3 1968 25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115
 30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16401									
CERTIFICATE OF DEATH									
16392									
1. DECEASED-NAME (Type or print) Charles W. Ross					2a. DATE OF DEATH Month 12 Day 25 Year 67		2b. HOUR M		
3 SEX male		4 RACE Colored		5. DATE OF BIRTH 1/15/27		6 AGE (In years last birthday) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a BIRTH PLACE (State or foreign country) Maryland		7b. COUNTRY OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give free address) U.S. General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Seaman		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) 517 1/2 1st St. S.W. Annapolis		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1st St.	
14. FATHER'S NAME John Walter Ross		15. MOTHER'S MAIDEN NAME Emma Green		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) yes					
16b. SOCIAL SECURITY NO. 219-12-3264		17. INFORMANT Frederic Ross - Annapolis Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coronary failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 8-3-56 , 19 56 , to 12-25 , 19 67 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A.T. Allen		DEGREE A.T. ALLEN		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-26-67			
22d. PHYSICIAN'S NAME (Type) A.T. ALLEN		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/28/67		23c. NAME OF CEMETERY OR CREMATORY St. Marys		23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md.			
24. FUNERAL DIRECTOR William Gease		ADDRESS 4 - Annapolis		25a. REC'D BY REGISTRAR DEC 27 1967		25b. REGISTRAR'S SIGNATURE John G. ...			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 4, and 5 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G396 1/5/68 lck

16402

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16393

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN It 1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY AA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 333 Crosswell Rd. e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANK H. ROWE		4. DATE OF DEATH Month December Day 29 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8/1909
9. AGE (in years lost birthday) 58 yrs		10. IF UNDER 1 YEAR Months 24 Days 24 Hours 24 Min 24	
10a. U.S. J.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Mer Marine		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter Rowe		14. MOTHER'S MAIDEN NAME Unk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO Family	
17. INFORMANT Same		Address Same	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 977X IMMEDIATE CAUSE (a) Exsanguination DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Laceration of the arm DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subject found with extensive lacerations and suicide note			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Subject found with extensive lacerations and suicide note	
20a. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Subject found with extensive lacerations and suicide note		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home	
20c. TIME OF INJURY Month, Day, Year 12 29 1967		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Baltimore A. A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inquest <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		22. DATE SIGNED December 30, 1967	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/2/68	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem		23d. LOCATION (City or town) (County) (State) Glen Burnie AA Co Md	
24. FUNERAL DIRECTOR McCully F.H. v37 Potomac ave		25. REC'D BY REGISTRAR JAN 2 1968	
25a. REGISTRAR'S SIGNATURE 2/12/68		25b. REGISTRAR'S SIGNATURE 2/12/68	



CERTIFICATE OF DEATH

16403

16394

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1. PLACE OF DEATH a. COUNTY <u>H.A. Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>H.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> d. STREET ADDRESS <u>316 N. GLEN AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EFFIE</u> First Middle Last <u>MAY SANDS</u>		4. DATE OF DEATH Month Day Year <u>12 9 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5-30-1884</u> 9. AGE (In years last birthday) <u>83</u> 10. IF UNDER 1 YEAR: Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CIVIL SERVICE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ANNAPOLIS, MD.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES FREEMAN</u>		14. MOTHER'S MAIDEN NAME <u>EMELINE JONES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>NORMAN E. SANDS #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Vaginal Hemorrhage</u> DUE TO <u>171X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Continued to the Central for Advanced</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> <u>59 min</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1967</u> , 19 <u>12/9/67</u> , to <u>12/14/67</u> , that (I) (we) last saw the deceased alive on <u>12/9/67</u> , and that death occurred at <u>12/14/67</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Albert L. Anderson</u>		22b. DATE SIGNED <u>12/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT L. ANDERSON MD 44 South Gales Lane Annapolis MD</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12-12-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR Bluff</u>	23d. LOCATION (City or town) (County) (State) <u>ANNAPOLIS H.A. MD.</u>
24. FUNERAL DIRECTOR <u>John M. Lyles</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>DEC 14 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (1)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16404						16395					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
Anne Arundel			Pasadena, Md.			Maryland			Anne Arundel		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. LENGTH OF STAY IN MD			e. IS RESIDENCE ON A FARM?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
9 Winding Woodsway			14 yrs.								
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			6. COLOR OR RACE		
First Middle Last			Date Month Day Year			Male Female			White Black Other		
PAUL F. SCHAFER			December 14 19 67			male			White		
7. MARIED <input checked="" type="checkbox"/> NEVER MARIED <input type="checkbox"/>			8. DATE OF BIRTH			9. AGE (In years last birthday)			IF UNDER 1 YEAR IF UNDER 24 HRS.		
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			21 Oct 1924			43 yrs.			Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
pipefitter			F.M.M. Inc. Co.			Baltimore, Maryland			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME								
Paul H. Schafer			Antoinie Rosenboom								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address		
no			216-20-7305			Pearl F. Schafer - wife - Same as # 2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)									2 days		
10 + X DUE TO									3 mos		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									18 mos		
(b) Anemia											
(c) CA of RECTUM											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
19											
21. I certify that (I) (this hospital) attended the deceased from JAN 19 66 to DEC 19 67, that (I) (was) last saw the deceased alive on DEC 13 19 67, and that death occurred at 4 P.M. from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
C. Earl Hill						12-15-67					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
C. Earl Hill, M. D.						395 Ft. Smallwood Rd., Pasadena, Md. 2112					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
Burial			18 Dec. 1967			Glen Haven Memorial Pk.			Glen Burnie, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Robert P. P. Singleton Funeral Home/ Glen Burnie, Md.						DATE DEC 18 1967			R. J. Jones		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

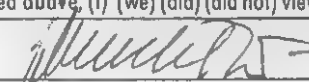
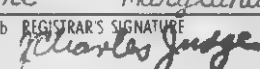
MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
16405		16396	
1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sherwood Forest	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 715 Robin Hill	
3 NAME OF DECEASED (Type or print) Frank Lysander SCOTT		4 DATE OF DEATH Month December Day 23 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 21, 1883
9. AGE (In years last birthday) 84 yrs		IF UNDER 1 YEAR Months 23 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DEPT STORE		10b. KIND OF BUSINESS OR INDUSTRY DEPT STORE RETAIL	
11 BIRTHPLACE (County & State, or foreign country) Iowa		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME DAVID H. SCOTT		14. MOTHER'S MAIDEN NAME MARIA M^C CULLOUGH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 212-09-9415	
17. INFORMANT F. BERTRAM SCOTT #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Arteriosclerosis DUE TO (c) many years		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)) Ileus due to I (a) above. Septicemia due to ileus.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 19, 1966 to Dec 23, 1967 , that (I) (we) last saw the deceased alive on Dec 23, 1967 , and that death occurred at 7:22 PM from causes and on the date stated above.			
22a. SIGNATURE <i>Charles W. Kinzer</i>		22b. DATE SIGNED Dec 24, 1967	
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.		22d. ADDRESS 16 Murray Avenue Annapolis, Maryland 21401	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 12/27/1967	23c. NAME OF CEMETERY OR CREMATORY PINE GROVE UNITED BRETHREN	23d. LOCATION (City or Town) (County) (State) RAYSVILLE MD
24. FUNERAL DIRECTOR JOHN M TAYLOR, SON ANNAPOLIS MD		25a. REC'D BY REGISTRAR DEC 27 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



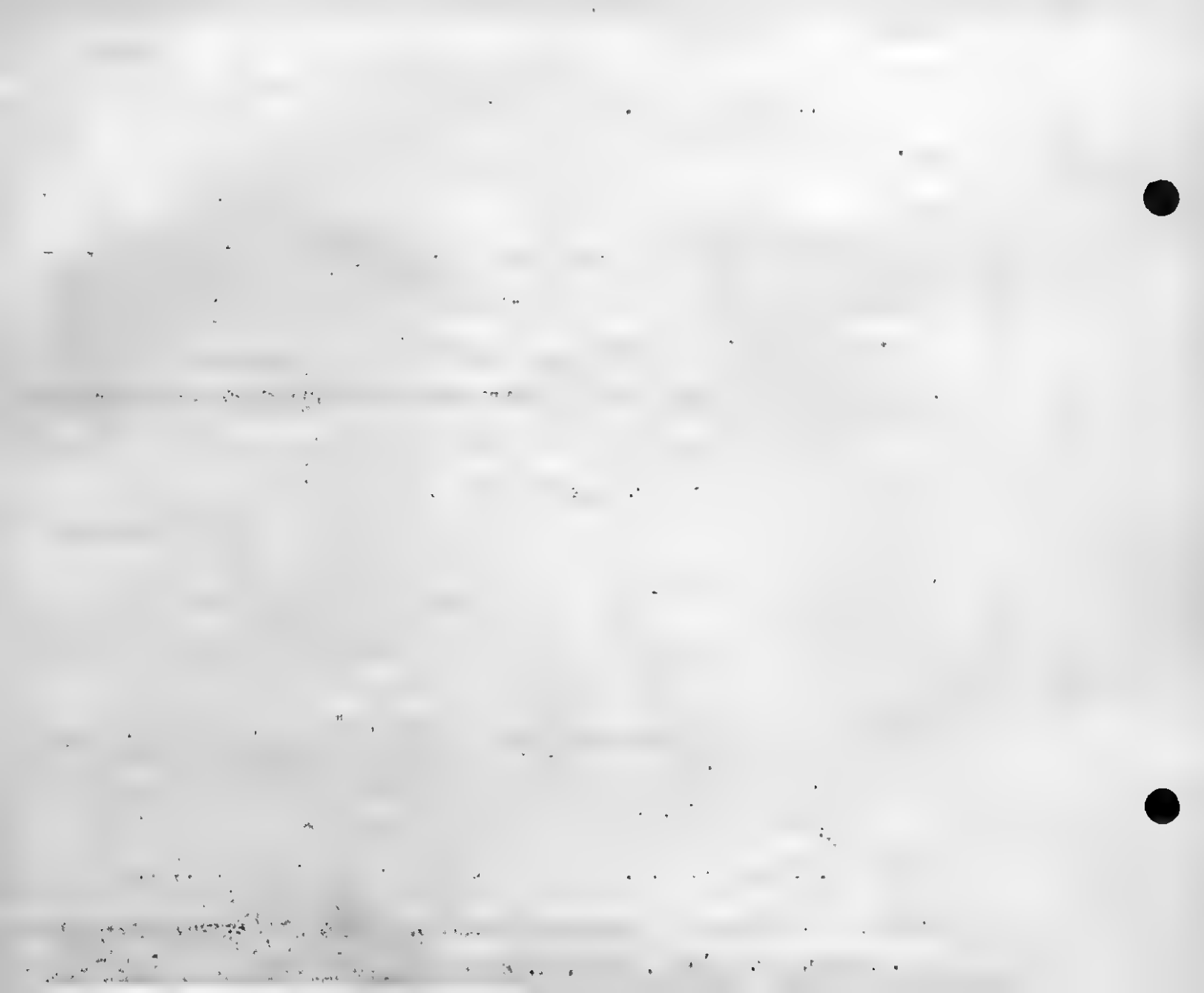
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-40
30M REV. 1-68

16406										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16397									
CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or print)			First Theodore			Middle M.			Last Seal			2a. DATE OF DEATH Month 12			Day 29			Year 67			2b. HOUR 2:00 PM								
3. SEX Male			4. RACE White			5. DATE OF BIRTH 10/28/16			6. AGE (in years last birthday) 51 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN														
7a. BIRTHPLACE (State or foreign country) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md																				
10. CITY OR TOWN OF DEATH Crownsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Railroad Engineer			12b. KIND OF BUSINESS OR INDUSTRY -----																				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY -- //			13c. CITY OR TOWN Baltimore			3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 5605 Denwood Avenue																	
14. FATHER'S NAME First Theodore			Middle M.			Last Seal			15. MOTHER'S MAIDEN NAME First Annie			Middle Hicks			Last Hicks														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO (If yes give war or dates of service) Unknown			17. INFORMANT Address Hospital Records, Crownsville Maryland																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>over</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Urinary Tract Infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypertension, Peptic Ulcer</u>																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that he (this hospital) attended the deceased from <u>12/9</u> , 19 <u>67</u> , to <u>12/29</u> , 19 <u>67</u> , that he (we) last saw the deceased alive on <u>12/29</u> , 19 <u>67</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE 			DEGREE L. Benedict, M.D.			ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12/29/67																				
22d. PHYSICIAN'S NAME (Type) L. Benedict, M.D.			22e. ADDRESS Crownsville State Hosp., Maryland																										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1/2/68			23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore Maryland																				
24. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Balto. St. Balto			ADDRESS			25a. REC'D BY REGISTRAR DATE JAN 3 1968			25b. REGISTRAR'S SIGNATURE 																				

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16407

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16398

1 PLACE OF DEATH a. COUNTY AACO MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Res. den. before adm. ssion) a. STATE MD b. COUNTY AACO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW BURNIE		c. LENGTH OF STAY IN 1b HANOVER	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A - NORTH		d. STREET ADDRESS 109 Post-Road	
3 NAME OF DECEASED (Type or print) First Dwight Middle R. Last Simms		4. DATE OF DEATH Month 12 Day 14 Year 1967	
5 SEX MALE	6 COLOR OR RACE N	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-27-1949
9 AGE (In years lost birthday) yrs 18		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	
10b. KIND OF BUSINESS OR INDUSTRY PLASTIC PLANT		11 BIRTHPLACE (State or foreign country) HARMONS, Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Charles H. Simms	
14 MOTHER'S M.A.D.E.N. NAME ESTHER MAE BAITHER		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16 SOCIAL SECURITY NO. 217-46-3332		17 INFORMANT MR. CHARLES H. SIMMS Address Box 109 Post Rd HANOVER, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 825.4 Multiple Fractures DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) auto accident	
20c. TIME OF INJURY Month Day Year Hour a.m. 12-14 1967 p.m.		20d. INJURY OCCURRED Where <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not Where <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) HANOVER MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. Linhart		22. DATE SIGNED 12-14-67	
EXAMINER'S NAME (Type) E. Linhart		23a. REC'D BY REG. STRAR DEC 20 1967	
23b. DAY THEREOF 12/18/67		23c. NAME OF CEMETERY OR CREMATORY SAINTS REST CEMETERY	
23d. LOCATION (City or town) (County) (State) HARMONS - ANNE ARUNDEL CO, MD		23e. REG. STRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR HERBERT E. NUTTER 3035 W. North Ave			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit if the pages 1 and 2 with the State Department of Health are presented prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

VR A15ME
6M 1/67

16408

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13399

1 PLACE OF DEATH a. COUNTY <u>H.A. CO.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE <u>MD</u> b. COUNTY <u>H.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GEN BURNIE</u>		c. LENGTH OF STAY IN 1b <u>HANOVER</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - NORTH ARUNDEL HOSP.</u>		e. STREET ADDRESS <u>109 Paul Road</u>	
3 NAME OF DECEASED (Type or print) First <u>Ellsworth</u> Middle <u>LEROY</u> Last <u>SIMMS</u>		4 DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>NEGRO</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-10-44</u>
9 AGE (in years last birthday) <u>23</u> yrs		10 IF UNDER 1 YEAR Months <u>12</u> Days <u>14</u> Hours <u>19</u> Min <u>67</u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Charles H. Simms</u>		14 MOTHER'S MAIDEN NAME <u>ESHER MAE GAITHER</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>214-40-0383</u>	
17 INFORMANT <u>MR. CHARLES H. SIMMS</u>		Address <u>BOX 109 POSTO HANOVER, MD</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>broken</u> DUE TO (c) <u>broken</u>			INTERVAL BETWEEN ONSET AND DEATH <u>broken</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auto accident</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) <u>Auto accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>pm</u> <u>12/14</u> 19 <u>67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>At home</u>	
20e. PLACE OF INJURY (Home form factory, street, office bldg, etc.) <u>At home</u>		20f. (City or town) (County) (State) <u>H.A. CO. MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Elin Harkett</u>		22. DATE SIGNED <u>12-14-67</u>	
EXAMINER'S NAME (Type) <u>Elin Harkett</u>		Address (Street, city, town or county) <u>HANOVER, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SAINTS REST CEMETERY</u>	23d. LOCATION (City or town) (County) (State) <u>HANOVER, ANNE ARUNDEL MD</u>
24. FUNERAL DIRECTOR <u>HERBERT E. NUTTER</u>		25. REC'D BY REGISTRAR <u>DEC 20 1967</u>	
ADDRESS <u>3035 W. North Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

16401

CERTIFICATE OF DEATH

16400

1 PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ORCHARD BEACH</u>		c. LENGTH OF STAY IN 1b <u>14 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ORCHARD BEACH</u>		d. STREET ADDRESS <u>1015 BELVEDERE PLACE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1015 BELVEDERE PLACE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>WILLIAM JOSEPH SMITH</u>		4 DATE OF DEATH <u>DECEMBER 8 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 14, 1912</u>
9. AGE (in years last birthday) <u>55 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>REVENUE SERVICE</u>		11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>CHARLES E. SMITH</u>	
14. MOTHER'S MAIDEN NAME <u>MARGARET A. CUCKLEY</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service) <u>YES WORLD WAR II</u>	
16. SOCIAL SECURITY NO. <u>216-01-3055</u>		17. INFORMANT <u>ANGELA SMITH</u> Address <u>1015 BELVEDERE PLACE</u>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Hypertensive-arter. CVD</u> DUE TO (c) <u>4 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <u>instantan.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1942, 19</u> , to <u>Dec 7, 1967</u> that (I) (we) last saw the deceased alive on <u>Dec 7, 1967</u> , and that death occurred at <u>7:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Kennard Yaffe</u>		22b. DATE SIGNED <u>12/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Kennard Yaffe, M.D.</u>		22d. ADDRESS <u>5501 Forest Park Ave, Balto Md #7</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12-11-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MD</u>
24. FUNERAL DIRECTOR'S NAME (Type) <u>Francis Dr. Miller 2101 Federal Ave. Balt.</u>		25a. REC'D BY REGISTRAR <u>DEC 11 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
16410									
10401									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 15		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchton				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital					d. STREET ADDRESS FRANKLIN MANOR			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Constance Helen SNYDER					4. DATE OF DEATH Month December Day 16 Year 19 67				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 3, 1901		9. AGE (In years last birthday) 66 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEWER		10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (County & State, or foreign country) GRAT BEND, PENNA			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles Herrick					14. MOTHER'S MAIDEN NAME Viola Whitman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 148 20 7380		17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of liver DUE TO carcinoma of bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)								INTERVAL BETWEEN ONSET AND DEATH 6 months 9 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 19 67 to Dec 16 67 , that (I) (we) last saw the deceased alive on Dec 15 19 67 , and that death occurred at 2:05 P.M. M, from causes and on the date stated above.									
22a. SIGNATURE Willard F. Smith				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/18/67			
22c. PHYSICIAN'S NAME (Type) Willard F. Smith M.D.				22d. ADDRESS Shady Side, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-18-67		23c. NAME OF CEMETERY OR CREMATORY Woodfield		23d. LOCATION (City or Town) (County) (State) Galesville AnCo Md			
24. FUNERAL DIRECTOR Handeedy Funeral Home				ADDRESS Coburnville Md		25a. REC'D BY REGISTRAR DATE DEC 26 1967		25b. REGISTRAR'S SIGNATURE William Judge	



x



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Al. A.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Al. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Steen Barnie</u>		c. LENGTH OF STAY IN 1b <u>Severna park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>W.O.A. North Prindle</u>		d. STREET ADDRESS <u>R. 1 Box 398</u>	
3 NAME OF DECEASED (Type or print) <u>Elijah Somerville</u>		4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Col.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-3-1909</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11 BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Somerville</u>		14 MOTHER'S M.A.D.E.N NAME <u>Lutera Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>214-14745</u>	
17. INFORMANT <u>Frances Somerville</u>		Address <u>Severna Park</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis of the Heart</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sub. diaphragmatic abscess</u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>8/12</u> , 19 <u>67</u> , to <u>12/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/15</u> , 19 <u>67</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Albert L. Anderson</u>		22b. DATE SIGNED <u>12/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT L. ANDERSON</u>		22d ADDRESS <u>44 Southgate Ave. Council Bluffs, Mo.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>12-19-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Carpenter Hill</u>	23d LOCATION (City or Town) (County) (State) <u>Round Bay MD</u>
24 FUNERAL DIRECTOR <u>William Reese</u>		25a REC'D BY REGISTRAR <u>DEC 18 1967</u>	
25b REGISTRAR'S SIGNATURE <u>William Reese</u>		25c REGISTRAR'S SIGNATURE <u>William Reese</u>	



CERTIFICATE OF DEATH

16403

16412

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>College of Tenses</u>		d. STREET ADDRESS <u>66 College St. Tenses</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Spencer</u>		4. DATE OF DEATH Month <u>12</u> - Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-19-1889</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>8</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (Country & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		13. MOTHER'S MAIDEN NAME <u>Matilda Jennings</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMATION <u>Albert Spencer, Baltimore</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diagnosed 1 mo before death</u> (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>A.C.O.D.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "a.m." <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>67</u> , to <u>Dec 8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 8</u> , 19 <u>67</u> , and that death occurred at <u>2:40</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Faye W. Allen</u>		22b. DATE SIGNED <u>12/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Faye W. Allen</u>		22d. ADDRESS <u>602 Cathedral St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-12-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore MD</u>
24. FUNERAL DIRECTOR <u>William Beasly</u>		25a. REC'D BY REGISTRAR <u>DEC 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			

FOR STATE
HEALTH DEPT.

16413

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16404

1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY 7			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY (If)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital				d. STREET ADDRESS Box 402 Race Track Road			
3. NAME OF DECEASED (Type or print) WILLIAM F. STEPPER				4. DATE OF DEATH Month December Day 12 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1934	9. AGE (in years last birthday) 37 yrs	10. IF UNDER 1 YEAR Months 12 Days 19 Hours 67		11. IF UNDER 24 HRS Hours 19 Min 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life (even if retired)) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY GEN. BLDG. TRADES		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BENJ. FRANKLIN STEPPER				14. MOTHER'S MAIDEN NAME ETHEL ROGERS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT PATRICIA ANN STEPPER		Address SAME AS #2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning DUE TO (b) 244 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) 244 DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Subject apparently drove into bridge and went into the water					
20c. TIME OF INJURY Month, Day, Year hour 7:00 p.m. 12 12 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Water		20f. (City or town) (County) (State) A. A. M.D.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE Edward F. Wilson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county) December 13, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE HEREOF 12/15/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEM.		23d. LOCATION (City or town) (County) (State) BALTIMORE, Md.	
24. FUNERAL DIRECTOR Charles J. Jones		ADDRESS 550 N. WASHINGTON BLVD.		25a. REC'D BY REGISTRAR DEC 15 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jones	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (10)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16416

10405

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Anne Arundel General Hospital		d. STREET ADDRESS 9 Monument Street	
3. NAME OF DECEASED (Type or print) KERNELL NMN STEVENS		4. DATE OF DEATH Dec. 23 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1910
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U.S. Naval Academy - shipmens		10b. KIND OF STONE STONE	9. AGE (in years and days) 57 yrs
11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George NMN Stevens		14. MOTHER'S MAIDEN NAME Lela NMN Porter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. II		16. SOCIAL SECURITY NO 214-05-1870	
17. INFORMANT Agnes J. Stevens		Address 9 Monument St. Anna. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 260x IMMEDIATE CAUSE (a) Cerebral Anoxia DUE TO (b) Asphyxia DUE TO (c) Respiratory Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E.G. LINHARDT		22. DATE SIGNED 12-23-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 26-67	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION (City or town) (County) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR C.E. Hicks 111 Annapolis, Md.		25a. REC'D BY REGISTRAR JAN 2 1968	
		25b. REGISTRAR'S SIGNATURE Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16415

16406

1 PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b Annapolis		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 14 Severn Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Mary Jones Louise TARR		4 DATE OF DEATH Month December Day 21 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH October 9, 1881
9 AGE (in years last birthday) 86 yrs		10 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY HOME	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME HENRY C. JONES		14 MOTHER'S MAIDEN NAME MARY SKINNER LE99	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 418 10 6946	
17 INFORMANT MRS. LOUISE BOETTCHER #2		Address 14 SEVERN AVENUE	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma, head of pancreas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1962 , to 12/21, 1962 , that (I) (we) last saw the deceased alive on 12/21, 1962 , and that death occurred at 8:15 P.M. from causes and on the date stated above.		22a SIGNATURE Richard I. Hochman, M.D. 22b DATE SIGNED 12/22/67	
22c PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d ADDRESS 16 Murray Avenue, Annapolis, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 12-26-67	
23c NAME OF CEMETERY OR CREMATORY Mt Olivet		23d LOCATION (City or Town) (County) (State) BALTO MD.	
24 FUNERAL DIRECTOR John M. V. G. & Sons		25a RECEIVED BY REGISTRAR DEC 28 1967 DATE 25b REGISTRAR'S SIGNATURE page	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16416

3407

1. PLACE OF DEATH a. COUNTY <u>Annapolis</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Annapolis</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Agnes General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Grace Thomas</u>		4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-1-1910</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Randolph Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Rosie Randall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>213-16-4058</u>	
17. INFORMANT <u>Rachel Parker</u>		Address <u>10 College Ct</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis due to Arteriosclerotic</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>November</u> , 19 <u>67</u> , to <u>Dec. 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec. 10</u> , 19 <u>67</u> , and that death occurred at <u>2:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>R. L. Richardson</u>		22b. DATE SIGNED <u>12-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. L. Richardson, M.D.</u>		22d. ADDRESS <u>110 Clay St., Annapolis, Md., 21401</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-13-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hopes Chapel Edgewater</u>	23d. LOCATION (City or Town) (County) (State) <u>MD</u>
24. FUNERAL DIRECTOR <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>DEC 13 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16417

16408

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 4 Bricin St.,	
3 NAME OF DECEASED (Type or print) First Alvin Middle Wesley Last TROTT		4 DATE OF DEATH Month December Day 6 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1926
9 AGE (In years last birthday) yrs 41		IF UNDER 1 YEAR Months 6 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Anne Arudel, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alvin J. Trott		14. MOTHER'S MAIDEN NAME ANNA CLARK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Joyce Trott #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic (to abd cavity, liver, retroperitoneal space) DUE TO (b) Oat cell carcinoma of L. lung DUE TO (c) 1 1/2 years			INTERVAL BETWEEN ONSET AND DEATH 3 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (1) John M. Verkous attended the deceased from July 66 to Dec. 5, 1967 , that (1) xxx last saw the deceased alive on Dec. 5, 1967 , and that death occurred at M , from causes and on the date stated above			
22a. SIGNATURE Peter F. Verkous		22b. DATE SIGNED Dec. 6, 67	
22c. PHYSICIAN'S NAME (Type) Peter F. Verkous, M.D.		22d. ADDRESS 1407 Forest Drive, Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12-9-67	23c. NAME OF CEMETERY OR CREMATORY Hillcrest	23d. LOCATION (City or town) (County) (State) Annapolis A.A. MD.
24. FUNERAL DIRECTOR John M. Verkous		25a. REC'D BY REGISTRAR DEC 8 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16418

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16409

1 PLACE OF DEATH a COUNTY <u>Annapolis</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Annapolis</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c LENGTH OF STAY IN 1b <u>031</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>General</u>		e STREET ADDRESS <u>29 paralel st</u>	
3 NAME OF DECEASED (Type or print) <u>Alice R. Turner</u>		4 DATE OF DEATH Month <u>12</u> Day <u>11</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Col.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-3-1919</u>
9 AGE (in years last birthday) <u>48</u> yrs		10 IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>19</u> Min <u>67</u>	
10a USUAL OCCUPATION (Give kind of work done during last working life event, etc.) <u>Domestic</u>		10b KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12 CITIZENSHIP (What country?) <u>U.S.A.</u>	
13 FATHER'S NAME <u>Jessie Parker</u>		14 MOTHER'S MAIDEN NAME <u>Georganna Smith</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv ice) <u>214242922</u>		16 SOCIAL SECURITY NO <u>Richard H. Turner</u>	
17 INFORMANT <u>Richard H. Turner</u>		Address <u>1000</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY <u>8354</u> IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Sudden</u> (c) <u>Heart</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Heart</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) <u>Heart</u>	
20c TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>12/11</u> 19 <u>67</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u>		20f (City or town) (County) (State) <u>Annapolis Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		22. DATE SIGNED <u>12/11/67</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		23a LOCATION (City or town) (County) <u>Annapolis Md</u>	
23b BURIAL CREMATION <u>Burial</u>		23c NAME OF CEMETERY OR CREMATORY <u>Prince Laidon</u>	
23d DATE THEREOF <u>12.16.1967</u>		23e ADDRESS <u>William Reese # Anna. Md.</u>	
24 FUNERAL DIRECTOR <u>William Reese # Anna. Md.</u>		25a RECEIVED BY REGISTRAR <u>DEC 13 1967</u>	
25b REGISTRAR'S SIGNATURE <u>James J. J.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16419

CERTIFICATE OF DEATH

164111

1 PLACE OF DEATH a COUNTY <u>Anne Arundel</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD.</u> b COUNTY <u>Anne Arundel</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville Md</u>			c LENGTH OF STAY IN 1b <u>@ 5 months.</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOLO MD.</u>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>@ Crownsville State Hosp. MD.</u>				d STREET ADDRESS <u>307 Haskell Dr.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>D.</u> Last <u>VIERLING</u>				4 DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1967</u>			
5 SEX <u>male</u>		6 COLOR OR RACE <u>Cau.</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 AGE (In years last birthday) <u>62</u> yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENG. WRITER</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Westinghouse</u>		11 BIRTHPLACE (County & State or foreign country) <u>N.Y.C. N.Y.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>HARRY S VIERLING</u>				14 MOTHER'S MAIDEN NAME <u>Mc Intosh</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO.</u>		16 SOCIAL SECURITY NO <u>084-09-5064</u> (wife)		17 INFORMANT <u>MRS DOROTHY S. VIERLING</u>		Address <u>ARNOLO MD. 307 Haskell Dr.</u>	
18a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>CHRONIC PULMONARY DISEASE (Emphysema)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) _____ (c) <u>ALZHEIMER'S Dis. & cerebral atrophy.</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)				
20c TIME OF INJURY Month, Day, Year Hour o m pm 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office b dg., etc.)		20f (City or town) (County) (State)	
21 I certify that (this hospital) attended the deceased from <u>7/21</u> , 19 <u>67</u> , to <u>12/2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/2</u> 19 <u>67</u> , and that death occurred at <u>6 PM</u> , from causes and on the date stated above							
22a SIGNATURE <u>Garrett M. Mays</u> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>12/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>GARRETT M. MAYS MD.</u>				22d. ADDRESS <u>CROWNsville STATE Hosp. MD.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5 Dec. 67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		23d LOCATION (City or Town) (County) (State) <u>Glen Burnie, Maryland</u>	
24 FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>				25a REC'D BY REGISTRAR <u>DEC 5 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
16420
CERTIFICATE OF DEATH

16411

1. DECEASED-NAME (Type or print) First Middle Last <u>William Henry Washington</u>			2a. DATE OF DEATH Month Day Year <u>12 27 67</u>			2b. HOUR <u>5:00a</u>					
3 SEX <u>Male</u>		4 RACE <u>Negro</u>		5. DATE OF BIRTH <u>1/23/97</u>		6 AGE (in years last birthday) <u>70</u> YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8 UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Anne Arundel</u> Md.					
10. CITY OR TOWN OF DEATH <u>Crownsville</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Crownsville State Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Unemployed</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Doek</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institut.on. Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>A A</u>		13c. CITY OR TOWN <u>Annapolis</u>		13d. INSIDE CITY LIM.TS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <u>8 cornhill Street</u>			
14 FATHER'S NAME First Middle Last <u>William Henry Washington</u>			15 MOTHER'S MAIDEN NAME First Middle Last <u>Annie ? NMN Nichols</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>Yes WWI</u>			16b. SOCIAL SECURITY NO. <u>218-10-4688</u>			17 INFORMANT Address <u>Hospital Records, Crownsville State Hospital</u>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>4937</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE PERIOD BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic Brain Syndrome, Diabetes Mellitus</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State							
22a. I certify that (H) (this hospital) attended the deceased from <u>9/9/</u> , 19 <u>59</u> , to <u>12/27/</u> , 19 <u>67</u> , that (H) (we) last saw the deceased alive on <u>12/27</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>		22c. DATE SIGNED <u>12/28/67</u>		22d. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>							
22e. ADDRESS <u>Crownsville State Hospital, Maryland</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-2-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Annapolis A.A. Co Md</u>					
24. FUNERAL DIRECTOR <u>Charles E. Hicks</u>		ADDRESS <u>Annapolis</u>		12b. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>JAN 5 1968</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Items #13 & 14 File #2206 12/27/67 ph											
16421											
CERTIFICATE OF DEATH											
10412											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green Berne MD</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FERNDALE</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North ARUNDEL CONU. CENT. 313 HOSP. DR.</u>						d. STREET ADDRESS <u>104 GORDON LANE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DALSY</u> First <u>M</u> Middle <u>WETIGAND</u> Last						4. DATE OF DEATH Month <u>Dec</u> Day <u>19</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1887</u>		9. AGE (in years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND (Baltimore)</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Wholey</u>						14. MOTHER'S MAIDEN NAME <u>Katherine Smith</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <u>Mrs Helen Walters</u>				Address <u>21061 1046 Gordon Lane</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Ventricular failure</u> DUE TO <u>hours</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarction</u> DUE TO <u>hours</u> (c) <u>Congestive heart failure</u> DUE TO <u>days</u>											
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis - fracture R-hip.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell in her own living room</u>							
20c. TIME OF INJURY Month, Day, Year <u>8:00 a.m. Nov 2 1967</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) <u>Home</u>		20f. (City or town) (County) (State) <u>Ferndale</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>12/8, 1967</u> to <u>12/19, 1967</u> , that (I) (we) lost saw the deceased alive on <u>Dec 14 1967</u> , and that death occurred at <u>9 AM</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>Max C Frank</u>						M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>12/19/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>MAX C FRANK MD</u>						22d. ADDRESS <u>425 SE Ritchie Hwy - Green Berne MD 21067</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Anne Arundel Co. Md.</u>			
24. FUNERAL DIRECTOR <u>M.C.F.H. V37</u>						25a. REC'D BY REGISTRAR <u>DEC 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 136 and 137 and 138 and 139 and 140 and 141 and 142 and 143 and 144 and 145 and 146 and 147 and 148 and 149 and 150 and 151 and 152 and 153 and 154 and 155 and 156 and 157 and 158 and 159 and 160 and 161 and 162 and 163 and 164 and 165 and 166 and 167 and 168 and 169 and 170 and 171 and 172 and 173 and 174 and 175 and 176 and 177 and 178 and 179 and 180 and 181 and 182 and 183 and 184 and 185 and 186 and 187 and 188 and 189 and 190 and 191 and 192 and 193 and 194 and 195 and 196 and 197 and 198 and 199 and 200 and 201 and 202 and 203 and 204 and 205 and 206 and 207 and 208 and 209 and 210 and 211 and 212 and 213 and 214 and 215 and 216 and 217 and 218 and 219 and 220 and 221 and 222 and 223 and 224 and 225 and 226 and 227 and 228 and 229 and 230 and 231 and 232 and 233 and 234 and 235 and 236 and 237 and 238 and 239 and 240 and 241 and 242 and 243 and 244 and 245 and 246 and 247 and 248 and 249 and 250 and 251 and 252 and 253 and 254 and 255 and 256 and 257 and 258 and 259 and 260 and 261 and 262 and 263 and 264 and 265 and 266 and 267 and 268 and 269 and 270 and 271 and 272 and 273 and 274 and 275 and 276 and 277 and 278 and 279 and 280 and 281 and 282 and 283 and 284 and 285 and 286 and 287 and 288 and 289 and 290 and 291 and 292 and 293 and 294 and 295 and 296 and 297 and 298 and 299 and 300 and 301 and 302 and 303 and 304 and 305 and 306 and 307 and 308 and 309 and 310 and 311 and 312 and 313 and 314 and 315 and 316 and 317 and 318 and 319 and 320 and 321 and 322 and 323 and 324 and 325 and 326 and 327 and 328 and 329 and 330 and 331 and 332 and 333 and 334 and 335 and 336 and 337 and 338 and 339 and 340 and 341 and 342 and 343 and 344 and 345 and 346 and 347 and 348 and 349 and 350 and 351 and 352 and 353 and 354 and 355 and 356 and 357 and 358 and 359 and 360 and 361 and 362 and 363 and 364 and 365 and 366 and 367 and 368 and 369 and 370 and 371 and 372 and 373 and 374 and 375 and 376 and 377 and 378 and 379 and 380 and 381 and 382 and 383 and 384 and 385 and 386 and 387 and 388 and 389 and 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640 and 641 and 642 and 643 and 644 and 645 and 646 and 647 and 648 and 649 and 650 and 651 and 652 and 653 and 654 and 655 and 656 and 657 and 658 and 659 and 660 and 661 and 662 and 663 and 664 and 665 and 666 and 667 and 668 and 669 and 670 and 671 and 672 and 673 and 674 and 675 and 676 and 677 and 678 and 679 and 680 and 681 and 682 and 683 and 684 and 685 and 686 and 687 and 688 and 689 and 690 and 691 and 692 and 693 and 694 and 695 and 696 and 697 and 698 and 699 and 700 and 701 and 702 and 703 and 704 and 705 and 706 and 707 and 708 and 709 and 710 and 711 and 712 and 713 and 714 and 715 and 716 and 717 and 718 and 719 and 720 and 721 and 722 and 723 and 724 and 725 and 726 and 727 and 728 and 729 and 730 and 731 and 732 and 733 and 734 and 735 and 736 and 737 and 738 and 739 and 740 and 741 and 742 and 743 and 744 and 745 and 746 and 747 and 748 and 749 and 750 and 751 and 752 and 753 and 754 and 755 and 756 and 757 and 758 and 759 and 760 and 761 and 762 and 763 and 764 and 765 and 766 and 767 and 768 and 769 and 770 and 771 and 772 and 773 and 774 and 775 and 776 and 777 and 778 and 779 and 780 and 781 and 782 and 783 and 784 and 785 and 786 and 787 and 788 and 789 and 790 and 791 and 792 and 793 and 794 and 795 and 796 and 797 and 798 and 799 and 800 and 801 and 802 and 803 and 804 and 805 and 806 and 807 and 808 and 809 and 810 and 811 and 812 and 813 and 814 and 815 and 816 and 817 and 818 and 819 and 820 and 821 and 822 and 823 and 824 and 825 and 826 and 827 and 828 and 829 and 830 and 831 and 832 and 833 and 834 and 835 and 836 and 837 and 838 and 839 and 840 and 841 and 842 and 843 and 844 and 845 and 846 and 847 and 848 and 849 and 850 and 851 and 852 and 853 and 854 and 855 and 856 and 857 and 858 and 859 and 860 and 861 and 862 and 863 and 864 and 865 and 866 and 867 and 868 and 869 and 870 and 871 and 872 and 873 and 874 and 875 and 876 and 877 and 878 and 879 and 880 and 881 and 882 and 883 and 884 and 885 and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000

MARYLAND STATE OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
16422									
16413									
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>H. H.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PATAPSCO PARK</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PATAPSCO PARK</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>221 SHENANDOAH AVENUE</i>					d. STREET ADDRESS <i>221 SHENANDOAH AVE.</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <i>ROBERT</i> Middle <i>JAMES</i> Last <i>WHEELER</i>					4. DATE OF DEATH Month <i>DEC.</i> Day <i>13,</i> Year <i>1967</i>				
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>COLORED</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-8-1879</i>		9. AGE (In years last birthday) <i>88</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>COOK</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>BALTIMORE, MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>JAMES WHEELER</i>					14. MOTHER'S MAIDEN NAME <i>ELEENORA?</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>217-05-7091</i>		17. INFORMANT Address <i>FLORENCE GRAY - 77-79 COLUMBIA ST., N. YL</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>440X</i> IMMEDIATE CAUSE (a) <i>Hypertensive Cardio-Vascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1 Jan 1964</i> to <i>13 Dec 1967</i> that (I) (we) last saw the deceased alive on <i>2 Dec 1967</i> and that death occurred at <i>11:00 AM</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>Renold B. Lighston</i>								22b. DATE SIGNED <i>15 Dec 67</i>	
22c. PHYSICIAN'S NAME (Type) <i>RENOLD B. LIGHSTON, M. D.</i>								22d. ADDRESS <i>501 CHERRY HILL RD., BALTO., MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b. DATE THEREOF <i>12-16-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MT. CALVARY</i>		23d. LOCATION (City, town or county) (State) <i>BALTIMORE, MARYLAND</i>	
24. FUNERAL DIRECTOR <i>Charles R. Law</i>				ADDRESS <i>802 MADISON AVE.</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 20 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (11)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16423

16414

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institor on Residence before admission) a. STATE <u>Ma/N/A</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
c. LENGTH OF STAY IN Tb <u>Life</u>		d. STREET ADDRESS <u>Box 428 N/A Jones Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Baby Peg</u>		4 DATE OF DEATH <u>Dec 19 1967</u>	
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B DATE OF BIRTH <u>12/10/67</u>	9 AGE (In years last birthday) yrs <u>11</u> Months <u>15</u>
8 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>heart</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	11 BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel, Md</u>
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	13 FATHER'S NAME <u>Milton Summerville</u>	14 MOTHER'S MAIDEN NAME <u>Glossie White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO <u>---</u>	17 INFORMANT <u>Glossie White Severna Park, Md</u> Address <u>---</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Major myocardial infarction</u> DUE TO <u>fracture</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) <u>---</u> (c) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Life</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>	20f (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>Dec 19, 1967</u> to <u>Dec 19, 1967</u> , that (I) (the hospital) saw the deceased alive on <u>Dec 19, 1967</u> , and that death occurred at <u>6:25 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Richard C. Lamy, M.D.</u>		22b DATE SIGNED <u>12/11/67</u>	
22c PHYSICIAN'S NAME (Type) <u>Richard C. Lamy, M.D.</u>		22d ADDRESS <u>South River Med Ctr. Edgewater, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>12/15/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Carpenter Hill</u>	23d LOCATION (City or Town) (County) (State) <u>Severna Park, Anne Arundel, Md</u>
24 FUNERAL DIRECTOR <u>Johnson's Funeral Home Ann, Md</u>		25a. REC'D BY REGISTRAR <u>---</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
DATE DEC 22 1967			



16424

CERTIFICATE OF DEATH

16415

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN Tb 10 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena, Md. d. STREET ADDRESS Forest Dr. Box 524 Rt. 10 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mildred E. White First Middle Last		4. DATE OF DEATH 12 21 19 67 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-26-09 9. AGE (In years last birthday) 58 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland
13. FATHER'S NAME William Anderson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Gladys Rowens, Pasadena, Maryland		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 445X DUE TO Coronary Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Hypertension with Atherosclerosis DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-21 , 19 67 , to 12-21 , 19 67 , that (I) (we) last saw the deceased alive on 12-21 , 19 67 , and that death occurred at 10:10 from causes and on the date stated above.			
22a. SIGNATURE Alejandro Montoya		22b. DATE SIGNED 12/21/67	
22c. PHYSICIAN'S NAME (Type) Alejandro Montoya, M.D.		22d. ADDRESS 707 Old Annapolis Rd., G.B. 21061	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 23 Dec. 67	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial	23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.
24. FUNERAL DIRECTOR Kirkley's Funeral Home, Glen Burnie		25a. REC'D BY REGISTRAR DEC 27 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Annus Wilson</i>			2a. DATE OF DEATH <i>12-12-1967</i>			2b. HOUR <i>M</i>	
3. SEX <i>Male</i>		4. RACE <i>Colored</i>		5. DATE OF BIRTH <i>10.3-1895</i>		6. AGE (In years last birthday) <i>72</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>A. A. Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i> Md	
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>A. A. General</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>A. A. Annapolis</i>		13c. INS. DE CITY, MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>102 South St.</i>	
14. FATHER'S NAME First <i>Ellie</i> Middle <i>Wilson</i> Last <i>Wilson</i>		15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Wilson</i> Last <i>Wilson</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Maggie Foote</i> Address <i>102 South St.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: <i>4330</i> IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiac failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>9-4-5</i> , 19 <i>12-12-67</i> , to <i>12-12-67</i> , 19 <i>12-12-67</i> , that (I) (we) lost the deceased alive on <i>12-12-67</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>A. T. Allen</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12-14-67</i>	
22d. PHYSICIAN'S NAME (Type) <i>A. T. ALLEN</i>		22e. ADDRESS <i>62 Calhoun</i>					
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>12-16-1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fonsters</i>		23d. LOCATION (City or Town) (County) (State) <i>Annapolis Md.</i>	
24. FUNERAL DIRECTOR <i>William Reese</i>				25a. REC'D BY REGISTRAR <i>W. L. 15</i> DATE <i>12-15-67</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16425

16417

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN lb 12 yrs.		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND		b. COUNTY Washington, D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Children's Center Hospital		e. STREET ADDRESS 233- 12th Place, N. E.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) John		4. DATE OF DEATH December 1 1967	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-15-48		9. AGE (In years last birthday) 19 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institutionalized		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John P. Winebrenner	
14. MOTHER'S MAIDEN NAME Annie Mae Winebrenner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Children's Center Hospital, Laurel, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a) ASPIRATION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MENTAL RETARDATION DUE TO (c) EPILEPSY	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		21. I certify that (I) (this hospital) attended the deceased from... February 4, 1955 to December 1, 1967 that (I) (we) last saw the deceased alive on... November 30, 1967 , and that death occurred at 10:00 am from the causes and on the date stated above.	
22a. SIGNATURE William Frank		22b. DATE SIGNED Dec. 1, 1967		22c. PHYSICIAN'S NAME (Type) WILLIAM FRANK, M. D.		22d. ADDRESS Children's Center Hospital, Laurel, Md.		23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 12-5-67	
23c. NAME OF CEMETERY OR CREMATORY Children's Center		23d. LOCATION (City, town or county) Laurel, Md.		23e. (State) A. A. Co.		24. FUNERAL DIRECTOR'S SIGNATURE Donaldson		25. REC'D BY REGISTRAR DEC 8 1967	
25. REGISTRAR'S SIGNATURE Charles Judge		26. REGISTRAR'S SIGNATURE Charles Judge		27. REGISTRAR'S SIGNATURE Charles Judge		28. REGISTRAR'S SIGNATURE Charles Judge		29. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been retained by the attending physician and completed, signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
16427											
10414											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN 1b <u>14 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rte. 2, Box 451, Point Pleasant</u>					d. STREET ADDRESS <u>Rte. 2, Box 451, Point Pleasant</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>N.</u> Last <u>Worthington</u>			4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1967</u>								
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8 May 1877</u>		9. AGE (In years last birthday) <u>90</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Howard County, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Joseph E. Worthington</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>217-01-1999</u>		17. INFORMANT <u>Mrs. Harry Christopher, same as 2</u>			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>443x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>Senescent arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>9/29/64</u> , 19 <u>64</u> , to <u>12/8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/8</u> , 19 <u>67</u> , and that death occurred at <u>3:55 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>William S. Linsao</u> M.D.					22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) <u>G. S. Linsao, M. D.</u>			
22d. ADDRESS <u>7308 Furnace Branch Rd., Glen Burnie, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>11 Dec. 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>			23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Maryland</u>			
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>					25a. REC'D BY REGISTRAR <u>DEC 12 1967</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sherwood Forest				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Clarence Martin WRIGHT					4 DATE OF DEATH Month December Day 18 Year 1967				
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8 DATE OF BIRTH April 3, 1905		9 AGE (In years last birthday) 62 yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Editor & writer		10b. KIND OF BUSINESS OR INDUSTRY News Letters		11 BIRTHPLACE (County & State, or foreign country) Texas			12 CITIZEN OF WHAT COUNTRY? U. S. A.		
13 FATHER'S NAME CLARENCE MARTIN					14. MOTHER'S MAIDEN NAME EVELYN MATHEWS				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16 SOCIAL SECURITY NO		17. INFORMANT ROSA DEE WRIGHT -wife- SAME AS #2			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism & Bronchitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH years	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. ——— 19 p.m. ———				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Sept. 1966 , to 12-18, 1967 , that (I) (we) lost saw the deceased alive on 12-18, 1967 , and that death occurred at 12:45 P.M. from causes and on the date stated above									
22a. SIGNATURE F.M. SHIPLEY					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-18-67		
22c PHYSICIAN'S NAME (Type) F.M. SHIPLEY					22d. ADDRESS Annapolis, Md				
23a B. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 12/22/67		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY			23d. LOCATION (City or Town) (County) (State) SUITLAND, PRINCE GEORGE, MD.		
24 FUNERAL DIRECTOR JOSEPH GAWLER'S SONS 5130 Wisc, Ave. N.W. Wash. DC					25a REC'D BY REGISTRAR DEC 28 1967		25b REGISTRAR'S SIGNATURE		

CERTIFICATE OF DEATH

16420

10420

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived if instituting Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 162 O'Berry Court	
3 NAME OF DECEASED (Type or print) Phillip Isiah WRIGHT		4 DATE OF DEATH Month December Day 25 Year 1967	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH January 20, 1920
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Engineer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Na. Acad.	9. AGE (in years last birthday) yrs. 47
11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME William C. Wright		14 MOTHER'S MAIDEN NAME Alberta Johnson	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 12-12-12-12	
17 INFORMANT Martha E. Wright - Annapolis, Md.		18 ADDRESS Annapolis, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Melanotic Carcinoma DUE TO (b) Carcinoma of Esophagus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2 DEC , 19 67 , to 25 DEC , 19 67 , that (I) (we) last saw the deceased alive on 25 DEC , 19 67 , and that death occurred at 2:30 P.M. from causes and on the date stated above.			
22a SIGNATURE Edward S. Beane		22b DATE SIGNED 12-26-67	
22c PHYSICIAN'S NAME (Type) William F. Beane, Jr. Annapolis, Md.		22d ADDRESS Annapolis, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial - 12/29/67 Pine Lawn		23b DATE THEREOF 12/29/67	
23c NAME OF CEMETERY OR CREMATORY Pine Lawn		23d LOCATION (City or town) (County) (State) Annapolis, Md. A. A. Md.	
24. FUNERAL DIRECTOR William F. Beane, Jr. Annapolis, Md.		25a REC'D BY REGISTRAR DATE DEC 27 1967	
		25b REGISTRAR'S SIGNATURE W. F. Beane, Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16430

CERTIFICATE OF DEATH

16421

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis MD</u>		c. LENGTH OF STAY IN 1b <u>RT 1 Box 493</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. Gen Hosp</u>		d. STREET ADDRESS <u>Armed md</u>	
3. NAME OF DECEASED (Type or print) <u>Lisak Ilmari Yttimaa</u> First Middle Last		4. DATE OF DEATH Month <u>12</u> - Day <u>2</u> - Year <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-91</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tavern Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Finland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>XXXXXXX Frans Lisak Yttimaa</u>		14. MOTHER'S MAIDEN NAME <u>XXXXXXX Hedvik Serafi Yttimaa</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>62 --</u>	
17. INFORMANT <u>Rt. 1, Box 493 Arnold, Md.</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>Raymond E. Yttimaa Mill Creek Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Cardiac arrest - Cong heart</u> DUE TO (b) <u>Acute myocardial Infarction</u> DUE TO (c) <u>ACVD</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>27</u> , to <u>1967</u> , 19 <u>27</u> , that (I) (we) last saw the deceased alive on <u>12-1-67</u> , and that death occurred at <u>10 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Hahn</u>		22b. DATE SIGNED <u>12-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		22d. ADDRESS <u>P.O. Box 73 Severna Park</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>John A. Moran, Inc. 3000 E. Baltimore St.</u>		25a. REC'D BY REGISTRAR <u>DEC 6 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

12031

12031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shen Burnie Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sanders Park, Pasadena, Md.</u>	
c. LENGTH OF STAY IN TB <u>yes</u>		d. STREET ADDRESS <u>Box 111A Rt. 11, Pasadena Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shen Burnie Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FREDERICK E. ZERRLAUT</u>		4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8/8/1908</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>16</u> Hours <u>16</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Homes</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Frederick Zerlaut</u>		14. MOTHER'S MAIDEN NAME <u>Ettla</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-10-2386</u>	
17. INFORMANT <u>Don Mary E. Montgomery</u>		Address <u>Box 111A Rt. 11</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/15, 1967</u> to <u>12/16, 1967</u> , that (I) (we) last saw the deceased alive on <u>12/15 1967</u> , and that death occurred at <u>9:54 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>J. Brady Smith</u>		22b. DATE SIGNED <u>12/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>		22d. ADDRESS <u>8471 FT. SMALLWOOD RD P.A., MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shen Haven Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Shen Burnie Md.</u>
24. FUNERAL DIRECTOR <u>John J. Cowen son Inc.</u>		25a. REC'D BY REGISTRAR <u>J. Hollins</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Hollins</u>		DATE <u>DEC 18 1967</u>	

